On The Edge of the Bench

an ethnographic study on health among socially marginalised men in a large Danish municipality

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AN ETHNOGRAPHIC STUDY ON HEALTH
AMONG SOCIALLY MARGINALISED MEN
IN A LARGE DANISH MUNICIPALITY

BY
ANNETTE PEDERSEN

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AALBORG UNIVERSITY
DENMARK

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An Ethnographic Study on Health among Socially Marginalised Men in a Large Danish Municipality

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CV

Annette Pedersen graduated from the nursing education programme at Aalborg Nursing School in 1993. Since 2016, Annette Pedersen has been a PhD student enrolled at the Department of Clinical Medicine at Aalborg University, Denmark. Her clinical nursing background is within intensive and emergency care and care for socially marginalised people. Since 2009, she has taught undergraduate nursing students at the School of Nursing at University College of Northern Denmark (UCN), where she currently holds a position as a senior lecturer. Her main subjects of interest are inequality in health, social marginalisation, exclusion, and organisational structures within the health system. Annette Pedersen has been engaged in research on the socially marginalised and curriculum development within this area.

SUMMARY

Unmet healthcare needs among marginalised populations have increased globally in recent years. This particularly concerns socially marginalised men who may find it difficult to understand and navigate the complex and fragmented healthcare system in different sectors. This is worrying from a public health perspective because these men often have complex care needs that also require the integration of healthcare and social services. Even though research points to different reasons for the inequality in health – such as strong association between health and social position – it still doesn't capture the individuals' perspectives. Consequently, this results in lack of insight into how socially marginalised men perceive health and how their perceptions influence their health behaviours and health-related help-seeking. It is therefore important to explore how to support socially marginalised men's health needs in a municipal context.

The overall aim of this PhD research was to explore the socially marginalised men's experiences and perceptions of health in the context of their everyday lives. The aim was also to explore municipal employees' experiences and perceptions of how to support socially marginalised men's healthcare needs and contribute with perspectives and clarification of possible challenges. The thesis is based on two substudies (1 & 2), allowing varying interpretations of how it is possible to support health based on contextual, social processes taking place in everyday life among the men. The two substudies are represented in three papers (I, II & III), each guided by specific objectives (A, B & C).

Substudy 1, objectives:

A: To explore health perceptions and health behaviours influencing overall health among socially marginalized men who seem to not benefit from existing healthcare in a large Danish municipality (Paper I)

B: To explore the factors that influence health-related help-seeking behaviour among socially marginalised men between 45 and 65 years of age in a large Danish municipality (Paper II)

Substudy 2, objective:

C: To explore municipal employees' experiences and perceptions of how to support healthcare needs among socially marginalised men between 45 and 65 years of age who currently seem not to benefit from municipal healthcare services in a large Danish municipality (Paper III)

This research used an ethnographic study design. Substudy 1 involved five months of fieldwork at two public bench sites in a large Danish municipality and interviews with 25 socially marginalised men between 45 and 65 years of age. Substudy 2 involved interviews with 21 managers and employees from two municipal policy sectors.

To answer the overall aim of the thesis, the findings from the two substudies were synthesised. The findings show that the men's health perceptions are tied up in their everyday lives and that they conceptualise health as what makes life worth living. Thereby, it seems significant that health professionals build respectful trust-based relationships with the men in order to obtain insight into the men's everyday lives and support their health needs. However, forming relationships may be a challenge, as the men have had poor previous experiences with different health services, such as not receiving the support they needed. At the same time, municipal employees have experienced challenges in supporting socially marginalised men because they often have

complex health needs. These complex needs require integration of social care and healthcare. Consequently, supporting the men's health needs has proven challenging and is dependent on relationships between the men and the professionals as well as the professionals' competencies and abilities to work across policy sectors and professional boundaries.

In sum, this research explored the socially marginalised men's experiences and perceptions of health in the context of their everyday lives as well as municipal employees' experiences and perceptions of how to support these men's healthcare needs and contribute to furthering research and clarification of possible challenges. This research highlights several issues of importance surrounding healthcare for socially marginalised men in order to construct targeted interventions to support the men's health needs. Nevertheless, it is important to acknowledge that this research's findings are simply the first step in order to support health needs among the men. The next step should be research on how to implement knowledge from this research in the municipality.

DANISH SUMMARY

Uopfyldte sundhedsbehov blandt marginaliserede borgere har været stigende i de seneste år, hvilket er bekymrende ud fra et folkesundhedsperspektiv. Dette gælder især socialt marginaliserede mænd, der kan have svært ved at forstå og navigere i det komplekse, fragmenterede og sektoropdelt sundhedssystem. Oftest har marginaliserede borgere komplekse sundhedsbehov, der relaterer sig både til deres sundhedsmæssige og sociale situation. Selv om forskning peger på at ulighed i sundhed er karakteriseret ved typiske mønstre i sammenhæng mellem sundhed, sygdom og den sociale position er det individuelle perspektiv underbelyst. Der manglende viden om hvordan socialt marginaliserede mænd opfatter sundhed, og hvordan deres opfattelser påvirker deres sundhedsopfattelse og sundhedsadfærd. Dette er vigtigt at undersøge for at kunne støtte socialt marginaliserede mænds sundhedsmæssige behov i en kommunal kontekst.

Det overordnede mål med denne forskning var at undersøge socialt marginaliserede mænds oplevelser og opfattelser af sundhed i relation til deres hverdagsliv. Målet var også at udforske kommunale medarbejderes oplevelser med og opfattelser af, hvordan man understøtter socialt marginaliserede mænds sundhedsbehov. Dette for at kunne bidrage til yderligere perspektivering og afklaring af mulige udfordringer.

Forskningen er baseret på to delstudier 1 & 2, der bl.a. afrapporteres i tre artikler (I, II og III). De to delstudier supplerede hinanden og bidrager med forskellige perspektiver på hvordan det er muligt at understøtte sundhed i relation til kontekstuelle forhold samt sociale processer, der finder sted i hverdagen blandt mændene. De to delstudier er repræsenteret i tre artikler med hver sin målsætning.

Delstudie 1, mål:

A: At undersøge sundhedsopfattelser og sundhedsadfærd, der påvirker den generelle sundhed blandt socialt marginaliserede mænd, der ser ud til ikke at drage fordel af eksisterende sundhedstilbud i en stor dansk kommune(Artikel I)

B: At undersøge de faktorer, der påvirker den sundhedssøgende adfærd blandt socialt marginaliserede mænd mellem 45 og 65 år i en stor dansk kommune (Artikel II)

Delstudie 2, mål:

C: At undersøge kommunale medarbejderes erfaringer med og opfattelser af, hvordan man kan understøtte sundhedsbehov hos socialt marginaliserede mænd mellem 45 og 65 år, der i øjeblikket ser ud til ikke at drage fordel af kommunale sundhedtilbud i en stor dansk kommune (Artikel III)

Et etnografisk studiedesign blev anvendt, hvor delstudie 1 omfattede fem måneders feltarbejde på to offentlige bænke i en stor dansk kommune samt interviews med 25 socialt marginaliserede mænd mellem 45-65 år. Delstudie 2 omfattede interviews med 21 ledere og medarbejdere fra to kommunale forvaltninger.

For at besvare det overordnede mål blev resultaterne fra de to delundersøgelser sammenfattet. Resultaterne viste, at mænds sundhedsopfattelser er tæt forbundet til deres hverdagsliv, og det, der gør livet værd at leve. Det synes derfor vigtigt, at sundhedsprofessionelle fokuserer på at opbygge en respektfuld tillidsbaseret relation til mændene. Dette kan give et særligt indblik i den enkelte mands hverdagsliv, hvilket øge muligheden for at støtte deres sundhedsmæssige behov. Der er dog udfordringer da flere af

mændene havde dårlige erfaringer fra tidligere kontakt med systemet såsom ikke at modtage den støtte, de havde behov for. Samtidig oplevede kommunale medarbejdere, at det kunne være en udfordring at støtte socialt marginaliserede mænd da mændene havde komplekse sundhedsmæssige behov, der krævede en integration mellem social- og sundheds tilbud. Derfor afhang støtte til mændene både af relationen mellem mændene og de sundhedsprofessionelle, men også af de sundhedsprofessionelles muligheder for at arbejde på tværs af forvaltnings- og faglige grænser.

Sammenfattende kan siges, at denne afhandling undersøgte de socialt marginaliserede mænds oplevelser og opfattelser af sundhed i relation til deres hverdagsliv samt kommunale medarbejderes oplevelser og opfattelser af, hvordan man understøtter disse mænds sundhedsbehov. Dette for at bidrage med yderligere perspektiver og afklaring på mulige udfordringer. Det er vigtigt at anerkende, at afhandlingens resultater kun er det første skridt på vejen til at støtte socialt marginaliserede mænds sundhed i en kommunal kontekst. Næste trin bør være en undersøgelse af, hvordan man implementerer denne forskningsviden i en kommunal kontekst.

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Thank you all for sharing this journey with me

Annette Pedersen, January 2020

LIST OF PAPERS

This thesis is based on the following papers:

Paper I

Pedersen, A., Haslund-Thomsen, H., Curtis, T., Grønkjær, M.
Health is Not All about Salads: An Ethnographic Study on Health Behaviour and Health Perceptions among Socially Marginalized Danish Men
Under review in *Public Health Nursing* on November 2, 2019.

Paper II

Pedersen, A., Haslund-Thomsen, H., Curtis, T., Grønkjær, M.
Talk to me, not at me: An ethnographic study on health-related help-seeking behavior among socially marginalized Danish men.
Published in *Qualitative Health Research* on August 28, 2019.

Paper III

Pedersen, A., Vardinghus-Nielsen, H., Curtis, T., Grønkjær, M., Haslund-Thomsen, H.
Healthcare Services to Socially Marginalized Men: A Qualitative Study on Municipal Employees' Experiences with Supporting Unmet Healthcare Needs.
Under review in *Nordisk Sygeplejeforskning* on May 2, 2019.

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1 INTRODUCTION

> *It is a little cold here early in the morning. I [researcher] go to the pavilion, where I meet him, sitting, reading a newspaper, drinking a cup of coffee and schnapps. We greet, and he invites me to sit down, pointing at the bench. Ashtrays, an empty flowerpot (for cigarette butts), beer cans and beer-bottle caps lie on the table in the pavilion. (…) I ask him how he is doing. "I am fine," he answers, "even though I'm in pain. I have pain in my back, my shoulders. In fact, in my whole body." He holds his hands forward, towards me. His fingers are in a fixed position, and he tells [me] he suffers from arthritis. Then he says: "But I do not mind it is hurting; I can be functional. It's not like others." He gesticulates. He pours another cup of coffee, followed by schnapps. We talk about the treatment he gets. He tells me about some prescriptive medication (morphine-like product) and continues, "I only take one pill a day. My doctor recommends two, but I simply walked around like in a dome, and I do not like that. No, I'm taking one pill in the morning, and then I take a joint in the afternoon, which helps. It makes me relax, and all the muscles relax. I never smoke so much that I get crooked. That's not what it's about."*

This extract is from fieldwork at a public bench site in Aalborg Municipality in 2016. The field note is an illustration of health challenges and their impact on daily life among socially marginalised men. In this thesis, I use the term *socially marginalised people* as an overall analytical concept to designate the people under study in this research. *Socially marginalised* in this research is defined as a combination of poor living conditions and lack of participation in a number of key areas of society: for example, low income, poor or no housing, social isolation or few social relationships, low or lack of professional or political participation, few recreational activities, and poor health (Larsen, 2009). In practice, among municipal employees and the literature used in this thesis, the terminology was not always consistent because different terms such as *low socio-economic status* (SES), *disadvantaged*, *marginalised*, and *hard to reach* were used. This makes the scientific work on socially marginalised complex, and to comply with such diversity, the concept *socially marginalised* will be further elaborated in Chapter 2, under The Concept of Social Marginalisation.

Much research on marginalised citizens has shown a complex picture regarding health. It is well known that socially marginalised people have poor physical and mental health, poor well-being, low health-related quality of life, and few and inadequate social relations (Ahlmark, 2018; P. Pedersen, 2009; P. Pedersen, Davidsen, Juel, & Holst, 2012; Rådet for Socialt udsatte, 2014). The same findings seem to apply among disadvantaged men with low educational levels and low SES (Noble, Paul, Turon, & Oldmeadow, 2015; OECD, 2017). Furthermore, an association between risky health behaviour, illness, and disabilities is demonstrated among citizens with low SES (Demakakos, Nazroo, Breeze, & Marmot, 2008; Mackenbach et al., 2008). This is coexistent with the fact that marginalised men and men with low SES are less likely to attend health services when needed (Amato & MacDonald, 2011; Daiski, 2007; Noble et al., 2015). However, Danish studies on marginalised men show that they have an excessive use of emergency services and general practitioners (Ahlmark, 2018; Benjaminsen, Birkelund, & Enemark, 2013; Juel, Davidsen, Pedersen, & Curtis, 2010; Rådet for Socialt udsatte, 2014; Strøbæk, Davidsen, & Pedersen, 2017). Paradoxically, socially marginalised men often view themselves as having good health which decreases with increasing stressful living conditions (Ahlmark, 2018), adding further complexity to the study.

Anecdotal evidence from an outreach team in Aalborg Municipality has identified a new group of socially marginalised men aged between 45 and 65 in the city scene who tend to have complex health challenges and who seem not to benefit from available healthcare services. Some of these men share characteristics similar to those illustrated in the fieldwork extract that introduced this chapter, such as arthritis and musculoskeletal challenges. The anecdotal evidence was from an outreach team conducting proactive social and healthcare initiatives for socially marginalised citizens. The team was comprised of health professionals, social workers, and social educators,

hereinafter called the Outreach Team (Bo- og Gadeteam, 2015). The newly identified group of socially marginalised men demonstrate some characteristics similar to other socially marginalised citizens proactively targeted by the Outreach Team – displaying risky health behaviour with daily alcohol use, tobacco smoking, poor diet, and lack of physical activity. However, anecdotal evidence also suggests that these men seem to differ from other socially marginalised citizens by appearing tidy and clean and by living in rented housing facilities, indicating that they are running their own households. The men position themselves slightly on the edge of where other socially marginalised people are located, such as at public bench sites. However, only anecdotal evidence exists on this group of socially marginalised men, and much uncertainty exists regarding their health and healthcare needs. Anecdotal evidence suggests that the men have healthcare resources available as long as they are willing to seek out the care needed; however, this is so far unsubstantiated. Much uncertainty also exists regards to scientific knowledge on how a municipality currently supports these men's health. These men's health may not differ from what previous studies have shown on other marginalised citizens, (Ahlmark, 2018; Demakakos et al., 2008; Noble et al., 2015; P. Pedersen et al., 2012) but it is unknown. Thus, it is relevant to examine this more closely because the concept of *marginalised* seems to vary greatly from study to study, and it is uncertain whether other research findings also apply to this study's men. Notwithstanding, I choose, as described by Moore and Stilgoe (Moore & Stilgoe, 2009) to accept the anecdotal evidence as an initial guide to this research on the grounds that the evidence represents a public health concern from the perspectives of the Outreach Team, which is in agreement with existing research showing that socially marginalised men have unmet health challenges. This triggered my curiosity and initiated this research.

This thesis is, in many ways, written "at the margin," as Kleinman (1995) described it (Kleinman, 1995). This figure of speech ties into this thesis in

several senses. It refers to the margin between medicine, nursing, and social work. Although I was enrolled at the Faculty of Medicine and situated in the Clinical Nursing Research Unit, Aalborg University Hospital, Denmark, I was never really studying medicine or clinical nursing in the narrow clinical sense. The phrase also illustrates how the participating men are positioned in relation to others, as socially marginalised. This will be further elaborated in Chapter 2, under The Concept of Social Marginalisation. Hence, the title of this thesis, *On the Edge of the Bench*, reflects a duality in that it refers to both a physical place and a dynamic situation where the participating men may walk in and out of the position of social marginalisation. My intentions have been to explore the socially marginalised men's experiences and perceptions of health in the context of their everyday lives. Therefore, I do not provide a monodisciplinary perspective, but rather a holistic perspective that opens to a broader understanding by using epidemiological knowledge and sociological, anthropological, and organisational perspectives in relation to studying the individual (the men) and the structural (the municipality as an organisation) positions. This thesis is written and conceptualised within the context of socially marginalised men's health (Ahlmark, 2018; Noble et al., 2015) and in conjunction with the fact that physical and psychosocial changes are more apparent in midlife than at other ages (Budetti, Schoen, Simantov, & Shikles, 2000; Wiltshire, Roberts, Brown, & Sarto, 2009).

In sum, the starting point of this thesis was contextual and two sided: Firstly, from a research perspective, the existing knowledge on health, health perceptions, and health-related help-seeking behaviour among the socially marginalised in a municipal context seemed limited as well as how the municipality experiences supporting these men's health. Secondly, from a public health perspective, contribution to this relevant area of research would be useful for the municipality in supporting healthcare needs among socially marginalised men. Consequently, I chose to pursue the anecdotal evidence and the complex paradox of socially marginalised men's health substantiated

in other studies; I explore this further in this research among socially marginalised men in Aalborg Municipality and discuss how a municipality currently support these men's health.

2 BACKGROUND

This thesis emanates from an ambition to engage with an ongoing public health dialogue on how the individual constructs health (Glasdam, 2009) and how health is perceived and lived out in relation to context and life circumstances. Thus, insight into perceptions, experiences, and current practices may contribute new perspectives to the field and discussion of the challenges of increasing inequality in health (Diderichsen, Scheele, & Little, 2015).

This chapter outlines the background for this thesis. Firstly, a short presentation on the Danish healthcare system is included for context; secondly, the main theoretical concepts used repeatedly in this research are briefly described; and thirdly, the state of the art is discussed, which is followed by rationales of this research, including overall aim and objectives.

2.1 DANISH HEALTHCARE SYSTEM AS STUDY CONTEXT

The Danish healthcare system is financed through general taxation. It is decentralised and provides universal access to services. All Danish residents are entitled to publicly funded healthcare, which is predominantly free of charge at the point of use (Olejaz et al., 2012). The healthcare system operates across three political and administrative levels: the state, the regions and the municipalities (national, regional, and local levels). The state holds the overall regulatory and supervisory functions in health and elderly care. The five regions are primarily responsible for the hospitals, the general practitioners (GPs), and psychiatric care (Ministry of Health, 2017). The 98 municipalities have, since 2007, held the responsibility for public health (Olejaz et al., 2012; Rigsrevisionen, 2013; Sølvhøj, Cloos, Jarlstrup, & Holmberg, 2017), with the purpose to achieve better integration with other

local services such as social, labour, and educational services (Diderichsen et al., 2015). The municipalities are responsible for managing health promotion, health prevention, elderly care, home care, social psychiatry, alcohol and other drug (AOD) treatment, and dental care (Olejaz et al., 2012; Rigsrevisionen, 2013; Sølvhøj et al., 2017). Such municipal efforts have aimed at reducing inequality in health (Diderichsen et al., 2015) by securing the Danish solidarity welfare model with equal access and quality in health services (Diderichsen, Andersen, & Manuel, 2012), with a relatively high degree of freedom and without too much control (Diderichsen et al., 2015). This research takes place within this framework of the Danish healthcare system.

2.2 MAIN THEORETICAL CONCEPTS

This section describes and discusses the main theoretical concepts used in this thesis: the concept of health, social marginalisation, and inequality in health. My intention with presenting the following theoretical concepts is that they offer some general guiding perceptions and directions as to where to look throughout the research process, which was based on pragmatic reasons resting on a general sense of what was relevant (Atkinson, 2015). The concepts assisted my reflections by providing perspectives on the research field, thus guiding the narrative literature review, strengthening the empirical and analytical focus in the analysis and the discussions of findings.

At this point, I would like to stress that I view these concepts as contextual. That means health, social marginalisation, and inequality in health may be associated with very different understandings based on context, professional points of view, and differences among individuals.

THE CONCEPT OF HEALTH

In defining health, there is no precise answer to what health entails, particularly because the concept is attributed to different meanings depending on the context in which the concept is used (Otto, 2009; Simovska, 2012). Green et al. (2015) argue that the meanings of health are socially constructed and difficult to define because health means different things to different people (Green, Tones, Cross, & Woodall, 2015). Thus, conceptualising health is value-laden and open to often opposing interpretations, which may be based on different scientific disciplines with varying preferences (Kamper-Jørgensen & Bruun Jensen, 2009).

One perspective on the concept of health arises within the biomedical field, which yields an understanding of health as the absence of illness and disease (Wackerhausen, 1994). Within this tradition, health is predominantly linked to the body's biology in a healthy-sick dichotomy, where pathogenesis has been predominant (Thybo, 2004), which makes sense as an explanation of the causes of infectious diseases and illness (Povlsen, 2013b; Sundhedsstyrelsen, 2005). However, some argue that the biomedical understanding of health portrays a negative tone, signifying a narrow perspective on health, which places the responsibility for being healthy entirely on the individual (Wackerhausen, 1994; Wistoft, 2012). This criticism is supported by others who argue that the biomedical understanding of health focuses entirely on the individual and his or her lifestyle, thereby disregarding social determinants that also may influence the individual's health (Crawford, 1980; Dybbroe & Kappel, 2012; Kristensen, Lim, & Askegaard, 2016).

Another perspective on the concept of health is inspired by the field of psychology, which bases its understanding of health on quality of life and well-being (Zachariae, 2014). Within this understanding, the salutogenic perspective from Aron Antonovsky (2000) seems well established (Simovska, 2012; Thybo, 2004). Antonovsky (2000) was interested in the origin and

development of health (salutogenesis) and, consequently, the factors and determinants that make people healthy instead of ill (Antonovsky, 2000; Thybo, 2004). From this perspective, health portrays a positive tone, signifying a broad perspective on health, which consequently conceptualises health as what makes life worth living (Wackerhausen, 1994; Wistoft, 2009). This indicates that health has potential and embedded possibilities (Dybbroe & Kappel, 2012), which accordingly may include quality of life and support from social relations (Simovska, 2012).

Even though health as a concept may be defined in varying ways (Vallgårda, Jørgensen, & Diderichsen, 2014; Wackerhausen, 1994), health is most often, in Western countries, conceptualised from the definition provided by WHO: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, n.d.). This definition established that health is not merely about feeling ill or not. The definition from WHO challenges the biomedical field's understanding by introducing a holistic view on health, and it has been critiqued. Leonardi (2018) argues that the definition is utopian because well-being becomes equal to health, which is not always the case. Another critique originates from a professional perspective, where Green et al. (2015) critique the definition because it equates health with well-being, which makes it difficult for health professionals to support citizens in an effective and meaningful way (Green et al., 2015).

In sum, health clearly seems complex to conceptualise and apply in a health-related professional practice. However, in this study, I am inspired by the broad health concept presented by WHO because it offers a framework that enables reflections on the participants attitudes and values thus these values constitute health as a concept created by the individual. Thus, health affects the way individuals make decisions in everyday life, including, in this case, both the socially marginalised men and the professional lives of the municipal employees.

THE CONCEPT OF SOCIAL MARGINALISATION

The Choice of Social Marginalisation as the Analytical Concept

This PhD journey started with an initial challenge in framing the target group of the study: the socially marginalised men. I learned this was difficult. In my early work, the difficulty I faced made me consider using concepts such as *hidden* and *invisible* in order to characterise the men. These terms were considered since these men do not typically use the welfare system and do not draw much attention to themselves regarding health. Therefore, the concept of *hidden* or *invisible* (Craig, Bejan, & Muskat, 2013; Larsen, 2005; Liamputtong, 2007; Watters & Biernacki, 1989; Wiebel, 1990) seemed useful. Larsen (2005) characterised *hidden* or *invisible* as people who often are omitted from national surveys, largely because they are more likely to be "hard to reach" and less likely to agree to an interview (Larsen, 2005). Furthermore, Larsen argues that hidden groups might be the ones benefitting the most from preventive efforts but are the least studied and least understood by clinicians and researchers (Larsen, 2002, 2004; Larsen & Sociologisk Institut, 2004). The description of hidden citizens in literature is, in many ways, comparable to the men under study in this research. However, these concepts developed over time and seemed not to capture the complexity of the men's situations, because none of the men were literally invisible, nor did they try to hide from others. Instead, *socially marginalised* was chosen because it is a concept recognised internationally (Benjaminsen, Andrade, Andersen, Enemark, & Birkelund, 2015) and expresses a dynamic process and not an inflexible position (Larsen, 2009). Hence only a few people live their entire lives as socially marginalised (SFI, 2016). In that way, the men in this study were not equally exposed socially or health-wise. However, choosing to use an overall concept such as social marginalisation is not without challenges. Firstly, some of the men describe themselves as marginalised; others would never do that, even though some, in a condescending voice, referred to themselves as "someone like me," meaning they were different than others. Secondly, the

use of this concept called for careful deliberation in the assessment of whether the men were socially marginalised, which will be elaborated on in Chapter 5, under Reflections on Research Process, Design, and Methods. An additional complexity to applying this concept was that the studies I have included in this thesis may use different concepts. For example, the Organisation for Economic Co-operation and Development (OECD) (2017) uses the term “low socio-economic status,” and Bryant et al. (2013) use the concept of “socially disadvantaged” others use “socially marginalised” which also include homeless and addicted people (Pedersen, 2018). However, it is important to emphasize the difference between the analytical concept of social marginalisation and the men associated with it. I use the concept to clarify, on a theoretical level, the characteristics of being socially marginalised and the processes behind social marginalisation. From a pragmatic point of view, this analytical distinction works on the premise that it is helpful and applicable (Brinkmann, 2006). Therefore, the rationale for maintaining such a particular linguistic meaning is a pragmatic choice based on a desire to maintain a certain social practice (Sørensen, 2010), with the understanding that we are talking about socially marginalised men and not men in general in this thesis.

What Does It Mean to Be Socially Marginalised?

The study population in this research is socially marginalised men with different types of social problems that hinder participation in one or several key areas of society. Often, *socially marginalised* is defined as people having AOD problems or suffering from poverty, homelessness, mental illness or prostitution (Council for the Socially Marginalised, 2017). However, not all people who have AOD problems or a mental illness are marginalised. Some researchers argue that by making such narrow categorization, we researchers risk designating specific population groups as marginalised instead of focusing on the processes and mechanisms that lie behind marginalisation and possible exclusion (Benjaminsen et al., 2015). Moreover, such narrow definition using risk groups or risk factors is limiting because it only refers to

risks and not necessarily a manifestation of social marginalisation (Larsen, 2009). Benjaminsen et al. (2015) argue that it is important to acknowledge that marginalisation is not solely associated with attachment to the labour market, education or income; it is also related to different aspects such as individual factors (control over own life, options available, autonomy); interpersonal factors (affiliation to social network, contact with others, social status, trust, entering communities); institutional factors (welfare payments, social and health services, organisation and coordination between services, prevention); and structural factors (labour market, income, housing conditions). Several components seem to have an impact on the risk of social marginalisation. According to Larsen (2009), *socially marginalised* is defined as a combination of poor living conditions and lack of participation in a number of key areas of society: for example, a socially marginalised person may deal with low income, poor housing circumstances or no housing, social isolation or few social relationships, low or lack of professional or political participation, few recreational activities, and poor health. This definition is in line with how I understand and use the concept *social marginalisation* in this thesis. This rather pragmatic definition was chosen to try to reach the men studied in this research, living at the margin of society. Their everyday lives differ from the everyday lives of most citizens in society. Anecdotal evidence stresses how they seem to spend their time sitting on a bench among others, drinking alcohol, and/or smoking marijuana, without participation in society as the majority of Danes: this dissimilarity, however, is directly dependent on the present picture of normality (Becker, 2005; Järvinen & Mortensen, 2002). To be marginalised implies being at the margin of arenas, institutions, and places that are usually assigned positive value in society or are affiliated with a workplace or family (Larsen, 2009), which are areas this study's men are devoid from. Thereby, marginalisation should be perceived as a dynamic position because it is possible to move in and out of the position in such a way that only a few people live their entire lives as socially marginalised (Benjaminsen et al., 2015; Larsen, 2005; SFI, 2016).

The Prevalence of Socially Marginalised Citizens in Denmark

In this section, I will highlight various characteristics that may contribute to social marginalisation to estimate the extent of social marginalisation and the risk of becoming socially marginalised. According to the Council for the Socially Marginalised, the number of poor people in Denmark rose to over 48,000 people in 2016, an increase of approximately 3,000 compared to the previous year. In 2012 a very comprehensive reform of early retirement and flex jobs was adopted in Denmark. This was a profound challenge to socially marginalised people because it became more difficult to get an early retirement pension. Coincident comprehensive employment reforms left beneficiaries of cash assistance struggling because they became poorer and had no employment prospects. A recent study stresses how 15 percent of all men aged 30–49 who receive cash assistance are experiencing homelessness (Rådet for Socialt Udsatte, 2018). According to the Danish National Institute of Public Health, some 147,000 people living in Denmark have an alcohol addiction, and under 16,000 people living in Denmark receive a publicly funded intervention for alcohol abuse which is just over 11 percent of dependent drinkers (Council for the Socially Marginalised, 2017). In 2009, the National Board of Health estimated that the number of drug users in Denmark is at 33,000. The Centre for Substance Abuse Research, on the other hand, estimates that the number of people with substance abuse treatment is rather 70,000–90,000, the majority of whom are hashish abusers (Rådet for socialt udsatte, 2016).

These statements are included in this section to clarify the extent of the problem that this research is concerning: health and healthcare needs among socially marginalised men. The men in focus in this study all have one or more of the following characteristics: having sparse connections to the labour market, being on social benefits, having poor finances, and having a daily

AOD consumption, which all may affect the possibility of moving out of the marginalised position.

THE CONCEPT OF INEQUALITY IN HEALTH

In this thesis, the concepts *inequality* and *inequity* are used synonymously because both concepts carry the same connotation of health differences that are unfair and unjust (Dahlgren & Whitehead, 2006; Vallgårda, 2008). Consequently, *inequality* will be used throughout this thesis based on the pragmatic reason that it is helpful and applicable (Brinkmann, 2006) and is therefore not discussed further.

Inequality and Inequity in Health

Unmet healthcare needs remain a significant global challenge (Schneider & Devitt, 2017), particularly among marginalised people (Burström, 2015; Diderichsen et al., 2012; P. Pedersen, 2009). In Denmark, inequality in health has increased, which is worrying from a public health perspective (Diderichsen et al., 2015). Such inequalities are a significant economic burden, because a large part of the population is ill and cannot contribute to society (Diderichsen et al., 2012). The increased inequality in health is a fact, even though Denmark, since the 1980s, has implemented the WHO programme known as the Global Strategy for Health for All by the Year 2000 in health policies and in health institutions throughout the country (WHO, 2005). This programme prompts all member states to consider the Health for All concept when formulating policies and action plans as a call for social justice, equity, and solidarity. In Denmark, this programme has been an inspiration to the national public health programme (Sundhedsstyrelsen & Kristensen, 2000). Inequality in health is an important concept in this study because socially marginalised men, in correlation with lifestyle (Bryant, Bonevski, Paul, & Lecathelinais, 2013; Freyer-Adam, Gaertner, Tobschall, & John, 2011; Noble et al., 2015; Sundhedsstyrelsen, 2014), and increase in age (Budetti et al., 2000; Wiltshire

et al., 2009), delay health-related help-seeking behaviour (Baker et al., 2014), and the fact that they tend not to benefit from the municipal healthcare may contribute to the deterioration of their health situation with further marginalisation. Thus, inequality in health is a multifaceted problem with significance for quality of life, cohesion, health, health expenses, and work ability. These are factors that may affect the possibility of moving out of a marginalised position (Diderichsen et al., 2015; Lau, Holm, Andersen, & Betina, 2012; Rådet for Socialt udsatte, 2014).

The Complexity of Social Inequality

Inequality in health is complex to grasp because different study results and understandings depend on the choice of outcome measurements and the definitions of social groups (Boström & Rosen, 2003). Vallgårda (2008) describes two different ways to define inequality in health – as a dichotomy or gradient. Dichotomy is the difference between a smaller marginalised group with major health problems and the rest of the population. Inequality understood as a gradient implies that increasing health challenges correlates with low SES: e.g., income and educational lengths (Vallgårda, 2008, 2009). Different resolution strategies are correlated to the way the concept is conceptualised. Hence, inequality conceptualised as a dichotomy may imply giving the weakest citizens a helping hand, whereas conceptualizing inequality as a gradient may imply creating greater equality in living conditions (Vallgårda, 2016) and efforts focused on health promotion and illness prevention (Diderichsen et al., 2012).

A plethora of research on health as a gradient has examined the association between socioeconomic well-being of individuals and health (Maskileyson, 2014). Within epidemiological research, various causes of inequality in health are pointed out, with 12 particular determinants highlighted as significant indicators of inequality (Dahlgren & Whitehead, 2006; Diderichsen et al., 2012). These determinants may influence health positively or negatively

(Dahlgren & Whitehead, 2006; Diderichsen et al., 2012, 2015). With regard to causes of inequality in health, it is not clear which determinants are most significant to address, because social group, gender, age, ethnicity, and geography all have high health-policy relevance (Diderichsen et al., 2012). However, a growing body of evidence strongly suggests how social inequality affects population health and well-being (Pickett & Wilkinson, 2015) and should be a prime focus when choosing strategies to reduce health inequality (Dahlgren & Whitehead, 2006). Everyday life may be complex because of SES, education, affiliation to the labour market, physical and social environment, and lifestyle, all of which may influence health. For that reason, the aim of this study is to explore the socially marginalised men's experiences and perceptions of health in the context of their everyday lives and also to explore municipal employees' experiences and perceptions of how to support these men's health needs.

2.3 OVERVIEW OF THE LITERATURE

In the following section, I will present the literature search, followed by a review of the literature, the state of the art, which implicitly display their authors theoretical sensitivity towards a target phenomenon (Sandelowski, 1993) and thereby act as a representation of the theories and knowledge in the field up to the current time. These theories and knowledge assisted in strengthening the empirical and analytical focus in the analysis and discussion of findings as well as forming the background for the two substudies comprised in this thesis.

LITERATURE SEARCH

A narrative literature review (Cronin, Ryan, & Coughlan, 2008) was conducted. One benefit was that a narrative literature review allows new insights and an openness to new approaches to the topic in focus that might otherwise be restricted by predefined frameworks or strict exclusion/inclusion criteria as used in a systematic review (Grough, 2012; Jesson, Matheson, &

Lacey, 2011). This narrative approach allowed me to obtain a broad perspective and use literature from across subject disciplines within different methodologies to summarize the body of literature relevant to the overall aim of this research. The search strategy was deliberately designed to capture a broad range of references (Cronin et al., 2008) and was continuously being developed, together with the refinement and clarification of the research question.

A variety of search strategies were used to ensure that the literature search was up to date from 2000 through August 2018. Selection criteria are shown in Table 1.

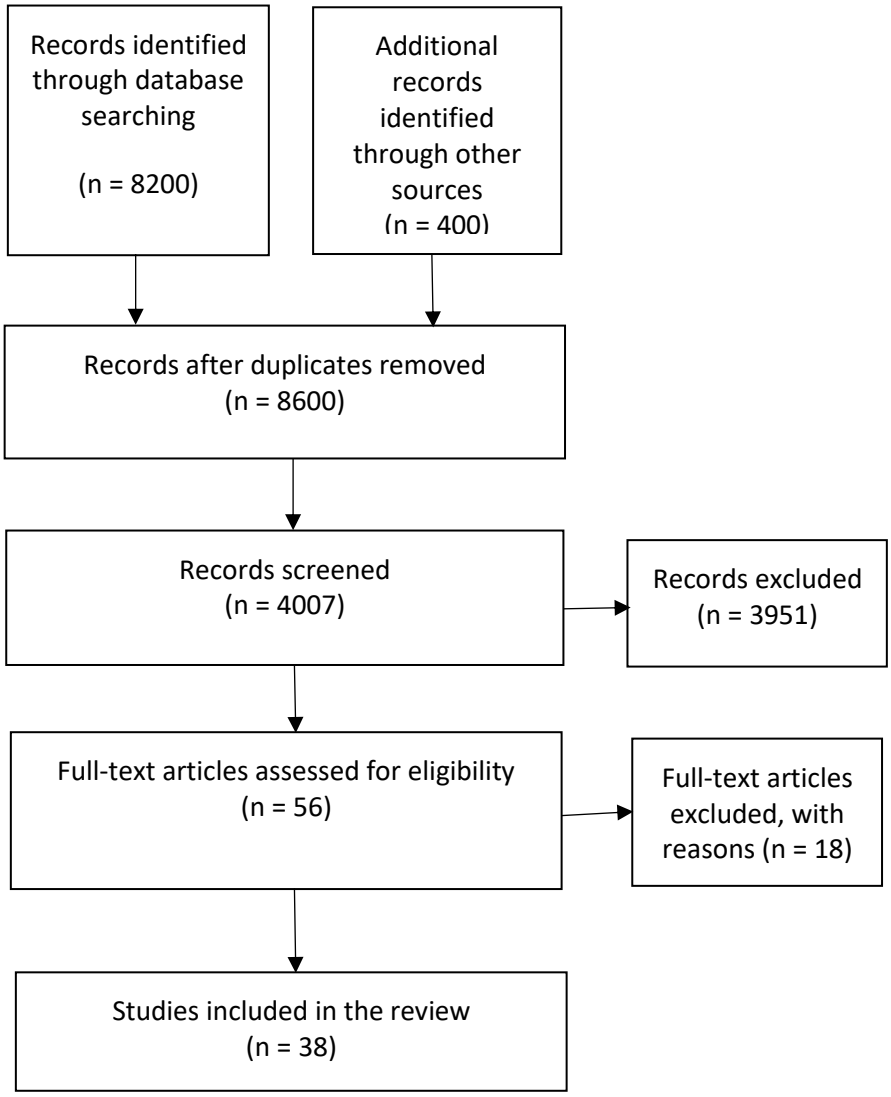
TABLE 1: SELECTION CRITERIAS IN THE LITERATURE SEARCH

Inclusion	**Exclusion**
• From year 2000 to 2018 • Comparable geographical areas • Municipal contexts • Men • Aged between 45 and 65 years • Health • Health perceptions • Health behaviour • Health-related help-seeking • Marginalised • Vulnerable • Low SES • Excluded	• Women • Children • Adolescent • Hospitalisation

Searches were conducted in the following databases: CINAHL Complete, PsychINFO, PubMed, and SveMed. CINAHL was searched because it covers nursing and rehabilitation from more than 900 English-language journals and, in addition to journal articles, selected books, pamphlets, dissertations, conference contributions, and standards. PubMed was searched because it covers the biomedical field, including nursing, medicine, and healthcare in general and is a comprehensive database. SveMed was searched because it covers Nordic health-professional literature.

Search strategies such as systematic database searches were conducted using the block-search strategy (Munch Kristiansen, Buus, Tingleff, & Blach Rossen, 2008; Polit & Beck, 2014). The databases were regularly searched using a combination of relevant search terms. Combinations of search words and synonyms will be apparent in excerpts from literature searches in Appendix A. The flow diagram in Figure 1 shows an overview of the literature search. This was supplemented by cascade searches using the following strategies: reading key references, examining controlled search words in relevant references, building these concepts into my own search strategy using Scopus with abstracts and citations of peer-reviewed literature, and checking “related articles” in PubMed or “find more like this” in CINAHL. Internet searches of books, reports, theses, etc. were also regularly conducted. Weekly searches were conducted to find new material and any updated material from selected journals and databases. Newspapers or other media reports that referred to new national and international studies were reviewed.

FIGURE 1 FLOW DIAGRAM OF LITERATURE SEARCH



The literature analysis strategy was inspired by Cronin (2008), wherein an initial first reading of the articles collected was conducted to get a sense of what they were about. This was followed by a systematic and critical review of the content according to this thesis' overall aim. Table 2 provides a summary of publications covering the overall aim of the study. The table includes a comment box, where I have noted which concepts were used in the study. This is to illustrate the diversity in concepts in the studies this research draws on.

TABLE 2. A SUMMARY OF PUBLICATIONS COVERING THE OVERALL AIM OF THIS RESEARCH

Reference	Aims	Design	Methods	Comments
(Amato & MacDonald, 2011)	This paper examined risk factors to homeless men, including amount of alcohol and drug use, length of homelessness, gender role conflict, and susceptibility to committing a violent act.	Hierarchical Regression Analysis	Survey	Uses the terms *marginalised* and *homeless*
(Noble et al., 2015)	Studies examining at least two SNAP risk factors (smoking, poor nutrition, excess alcohol consumption, physical inactivity).		Systematic review	Uses the terms *disadvantaged men* and *men in general*
(Daiski, 2007)	This paper is a report of a study of the perspectives of homeless individuals on their health and healthcare needs.	Qualitative	Semi-structured interviews and observational field notes	Uses the term *homeless*
(Coles et al., 2010)	This study aims not to rely on stereotypes, but rather to explore men's contextualised understandings of their health and prospective health-promotion campaigns, with the long-term goal of designing interventions that better reflect the needs of local men.	Qualitative	In-depth focus group interview	Use the term *men in deprived areas*

(Savage, Gillespie, & Lindsell, 2008)	The purpose of this study was to determine if those with a positive screen for problematic alcohol or drug use were at increased odds for having a lower health status and less access to care than those without problematic alcohol or drug use.	Quasi-experimental study design	Survey	Uses the term *homeless*
(Savage et al., 2015)	This study investigates attitudes toward help-seeking among non-help-seekers, drawn from a community survey in South London.	Qualitative	Interviews	Use the term m*ental disorders*
(Wiltshire et al., 2009)	This study assesses the effects of socioeconomic status (education and poverty) on seeking health information and subsequent use of this information during the medical encounter.	Quantitative	Survey	Use the term *socio-economic situation (SES)*
(Molarius et al., 2014)	This study investigates the existence of social inequalities in refraining from healthcare due to financial reasons in Sweden.	Quantitative	Questionnaire	Uses the terms *unemployed* and *disabled persons*
(Noonan, 2014)	The purpose of this integrative literature review was to investigate existing research on the reasons why patients delay seeking treatment for oral cancer symptoms from a primary healthcare professional.		Review	Use the term *socio-economic situation (SES)*
(Benjaminsen et al., 2013)	This report presents the results of a survey regarding illness and healthcare use among homeless citizens.	Quantitative	Register data	Grey literature Uses the term *homeless*

(Juel et al., 2010)	This report presents socially marginalised citizens' usage of the healthcare services.	Quantitative	Register	Grey literature Use the term *marginalised* – all groups from marginalised to excluded
(Rådet for Socialt udsatte, 2014)	This report deals with the health and diseases of socially marginalised people.	Quantitative	Survey	Grey literature Use the term *marginalised* – all groups from marginalised to excluded
(Strøbæk et al., 2017)	This study presents the mortality of the socially marginalised and their use of healthcare.	Quantitative	Register, Survey -	Grey literature Use the term *marginalised* – all groups from marginalised to excluded
(Hjelmar, Mikkelsen, & Pedersen, 2014)	This report presents an evaluation of incentive health efforts towards socially marginalised citizens.	Quantitative and qualitative	The evaluation is based on both qualitative and quantitative method	Grey literature Use the term *socially marginalised*
(Pedersen, 2009)	The purpose was to elaborate and nuance the picture of socially vulnerable people's health and to elaborate on the results of the questionnaire survey, SUSY Udsat.	Qualitative	Interviews	Use the term *marginalised* – all groups from marginalised to excluded
(Buck & Frosini, 2012)	The core purpose of this paper was to set out the implications for public health policy and practice.	Quantitative	Clustering by looking at two different years of a cross-sectional survey	Use the term *socio-economic situation (SES)*

(Freyer-Adam et al., 2011)	This study's aim was to determine a proportion of behaviour-related health-risk factors among jobseekers and to what extent these are related to self-rated health.	Quantitative	Multivariate logistic regression analyses	Uses the terms *jobseekers* and *risky health behaviour*
(Bryant et al., 2013)	This study's aim was to examine the prevalence and clustering of six health-risk behaviours (smoking, alcohol, inadequate sun protection, physical inactivity, and inadequate fruit-and-vegetable consumption) among severely disadvantaged individuals.	Quantitative	Cross-sectional survey	Uses the terms *typically hard-to-reach* and *severely disadvantaged*
(Diderichsen et al., 2012)	This report presents reasons and interventions related to inequality in health.		Review of existing international publications in the field, with particular regard to available Danish studies and the relevance in a Danish context	Grey literature Use the term *social inequality*
(Diderichsen et al., 2015)	This report presents views on social inequality in health, which has attracted significant political awareness and raised demands for action but has proven to be a difficult policy challenge to tackle.			Grey literature Use the term *social inequality*
(Secor-Turner & Hauff, 2014)	The purpose of this study was to describe homeless healthcare needs and barriers to healthcare access.	Qualitative part of a mixed methods study	Interviews	Uses the term *homeless*

(Andersen, Holtet, Weisbjerg, & Eriksen, 2016)	This report presents socially marginalised citizens' desires and possible unmet needs for alcohol treatment, addressing opportunities and barriers they experience in relation to being offered alcohol treatment as well as what experience they have in receiving alcohol treatment.	Qualitative and quantitative	Surveys and vignette method	Grey literature Use the term *socially marginalised*
(Lim, 2012)	This study assesses burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions.	Quantitative	Comparative risk assessment	Uses the terms *risk burden* and risk *factors*
(Ahlmark, 2018)	This report presents health profiles for socially marginalised people in Denmark since 2007.	Quantitative	Self-administrated surveys	Grey literature Use the term *marginalised*
(Marmot, Allen, Bell, Bloomer, & Goldblatt, 2012)	This study reviews data on social determinants of health and strategies to promote health equity within and between countries in the European region and the rest of the world.		Review	Use the term *social determinants*
(Molarius et al., 2007)	This study investigates the association between SES, material and psychosocial conditions, lifestyle factors, and self-rated health in the general population using a wide range of variables covering these factors.	Quantitative	Postal survey questionnaire sent to a random population sample	Uses the terms *socio-economic situation (SES) and general population*

(Bak, Andersen, & Dokkedal, 2015)	This study investigates the association between self-rated health and social position in ten deprived neighbourhoods.	Quantitative	Multiple logistic regression models	Use the term *deprived neighbourhoods*
(Pedersen, Grønbæk, & Curtis, 2012)	This study examines how disadvantaged life circumstances (homelessness, substance abuse, poverty) and general well-being are associated with poor self-rated health among the socially marginalised.	Quantitative	A nationwide survey	Use the term *socially marginalised*
(Schneider & Devitt, 2017)	This article examines the accessibility of healthcare in Ireland between 2003 and 2011 in the context of strong economic growth (2003–2007) and the subsequent financial crisis, which began in 2008.	Quantitative	Logistic regression analyses of cross-sectional data	Uses the terms *the full-time/part-time employed* and *individuals with poor health statuses*
(Pedersen, Hjelmar, Høybye, & Rod, 2017)	This paper examines the organisational dynamics that arise in health promotion aimed at reducing health inequalities.	Qualitative	Ethnographic fieldwork	Uses the terms *health inequalities* and *wicked problem*
(Holt, Rod, Waldorff, & Tjørnhøj-Thomsen, 2018)	This explorative study investigates intersectoral efforts for health in ten Danish municipalities.	Qualitative	Participant observation and interview	Uses the terms *social determinants* and *social inequalities in health*
(Hjelmar & Pedersen, 2015)	This study evaluates outreach social and health efforts towards socially marginalised citizens.		Evaluation of survey questionnaires	Use the term *socially marginalised*

(Rod, 2011)	This article looks more closely at the notions associated with impact evaluations and evidence-based practices. This article examines the consequences that the specialist language has had in municipal illness-prevention circles, and the evidence has gained widespread recognition	Qualitative	Ethnographic fieldwork	Uses *municipal practitioners working with health promotion*
(Pedersen, Haslund-Thomsen, Curtis, & Grønkjær, 2019)	This study explores socially marginalised men's health-related help-seeking.	Qualitative	Participant observations and interviews	Use the term *socially marginalised*
(Holt, Carey, & Rod, 2018)	This paper examines the role of organisational structure within government(s) in attempts to implement intersectoral action for health in Danish municipalities	Qualitative		Use the term *civil servants* from health and non-health sectors
(Roberts & de Souza, 2016)	This study evaluates the ability of an outreach health-check service to reach key target groups: men, people of South Asian ethnicity and people from deprived areas	Quantitative	Cross-sectional study using secondary data	Use the term *men in general* However, low SES showed delay help-seeking
(Sinclair & Alexander, 2012)	This study aims to understand the methods employed to achieve health-screening attendance.	Qualitative	Interviews	Use the term *hard to reach*
(Sundhedsstyrelsen & COWI, 2015)	This report presents health promotion in the communities.			Grey literature Use the term *social inequality*

REVIEW OF THE LITERATURE

This section presents the literature on previous knowledge and conceptualization framing the overall aim, starting with health and socially marginalised men, followed by healthcare services and socially marginalised men, followed by municipal healthcare to socially marginalised men, and finally followed by the rationales of exploring socially marginalised men's health.

Health and Socially Marginalised Men

Overall, the health burden is not distributed equally among socially marginalised men. For example, SES is a significant factor in causing inequality in health among men (Diderichsen, 2011; Diderichsen et al., 2015; Robertson & White, 2011), and Danish men with high education levels are expected to live longer than men with low education levels (OECD, 2017). There is an association between AOD use and social disadvantage, in that greater social disadvantages entail risky health behaviour (Noble et al., 2015). In particular, men with complex social problems such as low SES and unemployment display risky health behaviours, such as alcohol use and tobacco smoking (Bryant et al., 2013; Secor-Turner & Hauff, 2014). Among hard-to-reach, severely disadvantaged men (Bryant et al., 2013), low SES disadvantaged men (Noble et al., 2015), and job-seekers (Freyer-Adam et al., 2011), an association to poor diet and low levels of physical activity is displayed. It is well known that health behaviour can affect health both positively and negatively (Andersen et al., 2016; Diderichsen et al., 2012; Lim, 2012; Marmot et al., 2012). Thus, a significant social gradient in male risk-taking behaviour is observed among low SES disadvantaged men (Noble et al., 2015), among people with low SES and low educational level (Buck & Frosini, 2012), and among job-seekers (Freyer-Adam et al., 2011). Still, a national survey (Ahlmark, 2018) showed how socially marginalised men visiting different types of warm shelters, night cafés, and similar social

services self-rated their health positively; however, the positive ratings decrease in correlation with an increasing number of stressful living conditions such as AOD use and poverty. Other national (Bak et al., 2015; Pedersen et al., 2012) and international studies (Freyer-Adam et al., 2011; Molarius et al., 2007; Wu et al., 2013) demonstrated associations between low life circumstances and low self-ratings of health. Thereby, health among socially marginalised men is not consistent and seems complex, which might indicate that various factors may influence how an individual experiences and perceives health.

Healthcare Services and Socially Marginalised Men

Overall, marginalised citizens' utilisation of health services is complex. Internationally, this complexity relates to the fact that some studies show that socially marginalised men seem to display delayed help-seeking (Amato & MacDonald, 2011; Daiski, 2007). There seem to be various reasons for this delay. Previous negative experiences with the healthcare system results in delays in health-related help-seeking among people with mental disorders (H. Savage et al., 2015). Another study underlines how alcohol use and alcohol-related problems among homeless men affect their contact with the healthcare system, in that they are less likely to access healthcare when needed (Savage et al., 2008). And others again suggest that low education levels are negatively associated with a low motivation for health-related help-seeking (Wiltshire et al., 2009). And yet others show that delay in help-seeking among socially marginalised men is related to a low level of disposable income (Coles et al., 2010; Molarius et al., 2014; Noonan, 2014).

In Denmark, several surveys show that socially marginalised men have higher general practitioner (GP) attendance and higher hospital consultation rates than other citizens (Benjaminsen et al., 2013; Juel et al., 2010; Rådet for Socialt udsatte, 2014; Strøbæk et al., 2017). This may be related to the fact that healthcare in Denmark is largely free of charge for all citizens (Thomson,

Osborn, Squires, & Reed, 2011). However, some studies display that some socially marginalised men postpone or fail to contact the healthcare system because of poor experiences from past visits and a basic distrust of the system (Hjelmar et al., 2014; Ludvigsen & Brünés, 2013; Pedersen, 2009; Sundhedsstyrelsen, 2011, 2012). However, other research shows that socially marginalised men have higher use of healthcare compared with the rest of the Danish population (Ahlmark, 2018; Benjaminsen et al., 2013; Juel et al., 2010). The reasons for this seem complex, as Alhmark (2017) finds that there is a greater proportion of socially marginalized people with alcohol abuse or mental illness who have had contact with the health service than among the other marginalized groups. Whereas, Benjaminsen (2013) finds that citizens who have been homeless have a high morbidity and therefore have increased use of health care. As such, men's health-related help-seeking behaviour seems inconsistent and potentially influenced by a variety of factors.

Municipal Healthcare Services to Marginalised Men

Unmet healthcare needs remain a significant global challenge (Schneider & Devitt, 2017), especially among socially marginalised people, who typically have intertwined social and health problems (Pedersen, 2013; Secor-Turner & Hauff, 2014) and complex care needs that require integration of health and social services and labour services (Brostrøm, 2017; Toke & Vestergaard, 2017). This is worrying because one of the central challenges in the municipalities is to establish cooperation on disease prevention internally between different policy sectors and administrative departments such as the health, social, and labour management areas (Holt, Rod, et al., 2018). Unmet healthcare needs have increased more among marginalised citizens with low income than among any other population groups in recent years, which is worrying from a public health perspective (Burström, 2015). Research shows how such health inequality has proven to be a difficult policy challenge to tackle (Diderichsen et al., 2015) and is often referred to as a "wicked problem," defined as a difficult planning issue (Blackman et al., 2006; Rittel & Webber,

1973). An important issue is how municipalities may contribute to reducing inequality in health, since the responsibility for the public is assigned to the municipal level (Olejaz et al., 2012; Rigsrevisionen, 2013; Sølvhøj et al., 2017). Research demonstrates that health inequalities cannot be handled exclusively by the health sector but require involvement from different policy sectors (Pedersen et al., 2017). Thereby, the situation seems complex and is characterised by a wide range of different types of problems, which are difficult to separate (Hjelmar & Pedersen, 2015; Pedersen et al., 2017). One reason that it is complex may be that health promotion is not uniquely placed with health professionals but is also carried out by professionals with social and educational backgrounds, all with different professional rationales and practices (Rod, 2011) and often with opposite interpretations of health (Kamper-Jørgensen & Bruun Jensen, 2009). A recent study stresses that socially marginalised people are predominately unaware of municipal healthcare services (Pedersen et al., 2019). To accommodate less-resourceful Danish citizens' complex care needs, outreach health approaches have been initiated with overall success (Sundhedsstyrelsen & COWI, 2015). Even though the success of outreach approaches to different target groups could vary substantially by venue, outreach seems to be the best way to support hard-to-reach groups (Roberts & de Souza, 2016); thus some approaches were of immediate benefit to the individuals, such as health assessments and social advice (Hjelmar et al., 2014) and especially the personal touch from outreach professionals – their friendliness and respectfulness seemed to impact the citizens' decisions to attend health checks (Pedersen et al., 2019; Sinclair & Alexander, 2012). Although other research has established knowledge on municipal challenges in establishing cooperation in health promotion internally across policy sectors, much is uncertain about the specific challenges. This situation reflects a complex public health dilemma on how to support socially marginalised men with situations similar to this study's participating men.

2.4 RATIONALES FOR EXPLORING SOCIALLY MARGINALISED MEN'S HEALTH

Based on this narrative literature review, health among socially marginalised men seems complex and inconsistent and influenced by the individuals' perceptions and assessments of health. Furthermore, socially marginalised men's health-related help-seeking behaviour is inconsistent and potentially influenced by a variety of factors. Even though other research has established knowledge on municipal challenges in establishing cooperation for health promotion internally across policy sectors, much is uncertain and unsubstantiated in relation to the men in focus in this research, reflecting a complex public health dilemma. This complexity is related to the fact that unmet healthcare needs among marginalised populations have increased in recent years, which is worrying from a public health perspective (Baker et al., 2014; Burström, 2015; Diderichsen et al., 2015; Noble et al., 2015; Sundhedsstyrelsen, 2014; Wiltshire et al., 2009). Although the epidemiological research points to different reasons for the inequality in health and demonstrates a coherence between health, illness, and social position, it still does not capture the individual perspectives from the men in focus in this research. Consequently, there is lack of insight on how socially marginalised men perceive health and how their perceptions influence their health. Thus, it is relevant to explore health among socially marginalised men, using a methodology that allows for the understanding of contexts, processes, and meanings from the participants' perspectives. Such knowledge, as well as knowledge of how municipal employees experience being able to support men's health, is valuable in a municipal context to address the healthcare services available to these socially marginalised men or citizens in similar situations. The goal is to avoid further marginalisation that may lead to inequality in health.

2.5 OVERALL AIM AND RESEARCH OBJECTIVES

The overall aim of this PhD research was to explore the socially marginalised men's experiences and perceptions of health in the context of their everyday lives. The aim was also to explore municipal employees' experiences and perceptions of how to support socially marginalised men's healthcare needs and contribute with perspectives and clarification of possible challenges.

The thesis is based on two substudies (1 & 2), allowing interpretations between different views on how it is possible to support health based on contextual, social processes taking place in everyday life among the men. The two substudies are represented in three papers (I, II, & III), each guided by specific objectives (A, B & C).

Substudy 1, objectives:

> A: To explore health perceptions and health behaviours influencing overall health among socially marginalized men who seem to not benefit from existing healthcare in a large Danish municipality. (Paper I)
>
> B: To explore the factors that influence health-related help-seeking behaviour among socially marginalised men between 45 and 65 years of age in a large Danish municipality (Paper II)

Substudy 2, objective:

> C: To explore municipal employees' experiences and perceptions of how to support healthcare needs among socially marginalised men between 45 and 65 years of age who currently seem not to benefit from municipal healthcare services in a large Danish municipality (Paper III)

3 RESEARCH DESIGN

The overall aim of this PhD research was to explore the socially marginalised men's experiences and perceptions of health in the context of their everyday lives. The aim was also to explore municipal employees' experiences and perceptions of how to support socially marginalised men's healthcare needs and contribute with perspectives and clarification of possible challenges. To provide transparency, this chapter contains the philosophical assumptions, scientific perspectives relevant to the methodology, study setting, access, and descriptions of material and methods used to explore the aim and objectives of this study.

3.1 PHILOSOPHICAL PERSPECTIVE

In the following, I will briefly present the most central and relevant ideas of the pragmatic perspective relative to the methodology and methods used in this research. Ethnography as a qualitative methodology was chosen because it allows an exploration and description of individual and contextual influences, which leaves space for fluidity and flexibility (O'Reilly, 2012). It is a research process of learning about people by learning from them, thus exploring what people do and their reasons for doing so (Madden, 2010; O'Reilly, 2012). This enables the research process to unfold in the interactions between me and the participants, resulting in me learning about a diverse range of complex social phenomena (O'Reilly, 2012), from personal perceptions to organisational processes. Therefore, I chose the pragmatic perspective, thus viewing the world we live in as fluctuant, unstable, incomplete, and without a given form (Brinkmann, 2006; Dewey, 2005), which allows me to continuously ask the world questions and engage with it (Whyte, 1999).

True knowledge within ethnography is not definite or objective but an ideal relative to the way it is represented (Hastrup, 2013). That way, knowledge is

a special way of recognizing the world. It is relational, understood in the way that the individual is embedded in and contributes to the community (Hastrup, 2009a). Equally, within pragmatism, knowledge is socially constructed and considered a representation of the social practice between the researcher and the individual and previous experiences (Brinkmann, 2006; Dewey, 2005; J. Savage, 2000). Thus, knowledge is not given but must be invented together, whereby truth is not true merely because it is based on previous experiences, because our experiences are tied up and contextual and procedural (Brinkmann, 2006). This means that the pragmatic perspective leaves room for construction of multiple answers, which can be explored within the chosen ethnographic methodology (Hastrup, 2009a; Whyte, 1999), where possible patterns can be invoked or constructed to make sense of observed events within complex social settings.

By adopting the pragmatic perspective, I also emphasized an abductive logic which mean that based on my observations I drew out possible ideas to the question: What is this the case of? Such a dialogue with the ethnographic material is by Atkinson (2015) called ethnographic abduction and refers to how elaboration of guiding ideas emerged from the interaction between the theoretical concepts such as health, marginalisation and inequality and the ethnographic material. Thereby providing the theoretical foundation while keeping an openness towards the material. Pragmatism allowed such openness and assisted me in strengthening the empirical and analytical focus in the analysis and discussion of findings as well as forming the background for the two substudies comprised in this thesis.

Pragmatism is against the dualistic separation of subject and environment and is concerned with what currently makes sense, has consistency, acts in practice, and is constructively meaningful both individually and socially (ontological) (Brinkmann, 2006; Dewey, 2005). Participant observation, which is a significant part of this study's method, entails interaction in a social

network, which, according to Hastrup (2010a), implies that the subject and object cannot be separated absolutely (Hastrup, 2010a).

The collaborative, guiding form of the ethnographic interviews (O'Reilly, 2012) as well correlated the pragmatic perspective that knowledge is socially constructed and is a representation of the social practice between the participants and researcher (Whyte, 1999). Thereby these research methods are closely linked to the philosophical perspective.

3.2 ETHNOGRAPHY

In this section, I will briefly present the most central issues within the ethnographic methodology relevant to this research. This involves a short presentation of the municipality as the study's setting, the act of gaining access to the participants and municipality, a presentation of substudies 1 & 2, including methods used, and finally consideration of the researcher role.

Within the ethnographic methodology, special attention is given to how social life is constructed and how individual relationships, individual actions, and personal experiences work together. Ethnography allows for a special native point of view that is from an inside perspective, which can only be accessed through participation in the world of others', by assuming the reality of others' (Hastrup, 2010a).

Ethnography may provide a nuanced understanding of an organisation and allow for comparison between what people say and what they do (Hastrup, Rubow, & Tjørnhøj-Thomsen, 2017). Thus, this methodology seemed appropriate to explore how an organisation's formal structures influence the possibilities in supporting healthcare needs and how professional knowledge is locally produced in different settings. Using ethnography seemed a relevant choice because, as argued by Hastrup (2010a), it allows an attention to the human being as part of the social community. Participant observations and

ethnographic interviews with socially marginalised men and ethnographic interviews with municipal employees were chosen as methods to explore the actors' different perceptions. This ethnographic research has involved a constant to-and-from (an iteration), participating, observing, writing, reflecting, reading, thinking, talking, and listening in a circular, rather than a linear, way (O'Reilly, 2012). The ethnographic research strategy took form as the stepping-in-stepping-out ethnography, described by Madden (2010) as an engagement the researcher enters when working in familiar settings, thus only spending some of the day "in the field" and afterwards returning to their homes. As an example, participant observations in this study were primarily carried out at two bench sites repeatedly, which will be further elaborated later in this chapter, under substudy 1.

THE MUNICIPALITY AS STUDY SETTING

The overall setting was Aalborg Municipality, which has approximately 200,000 inhabitants. Aalborg Municipality is the third-largest municipality in Denmark. For many years, Aalborg was known as "The town with the smoking chimneys" – a thriving industrial city, where over half of the city's workforce followed the factory sirens every morning and flocked to assembly lines and machines. Spritten, Eternitten, and C.W. Obel's tobacco factory were some of the best-known factories, but there were hundreds of large and small industrial companies in Aalborg. Aalborg's business has been characterized by heavy industry and large unskilled workplaces, and Aalborg's working population was generally poorly educated compared to the rest of the country. Now most of the major industrial workplaces that were once Aalborg's landmarks are gone. They have either succumbed to competition or have moved production abroad – especially to Asia. Although new large industrial companies have arrived, it is a fact that only 15 percent of Aalborg's population now works with crafts and industry. On the other hand, 60 percent are engaged in administration and service (Nordjyllands Historiske Museum, n.d.).

The municipalities have used several different organisational models to solve their obligations for health promotion (Hansen, 2014). In Aalborg, the community health system [Det nære sundhedsvæsen] is responsible for the municipality's health, employment, and social sectors (Aalborg Kommune, 2015). Thereby health is an area of responsibility for the entire municipality. Aalborg Municipality has, among other things, established several community health centres to support the political goal that health services shall be adaptable to all citizens by being flexible and accessible (Sundheds- og Kulturforvaltningen, 2014). The municipality offers a wide range of health-promotion and disease-preventative options for its citizens, with advanced efforts located in various communities. That way the citizens may be treated or get support at home or in the local community, thus benefitting from proximity and continuity (Sundheds- og Kulturforvaltningen, 2014; Toke & Vestergaard, 2017). To support marginalised citizens, the municipality offers services such as the Outreach Team that offer health and social services to socially marginalised citizens and bridge to other parts of the overall healthcare and welfare system (Aalborg Kommune, 2015, 2019).

GAINING ACCESS TO THE FIELD AND THE PARTICIPANTS

To ensure close links with the municipality, a support monitor group was assigned to this study. The members of the group were senior managers and specialists within social and healthcare practices in two municipal departments, the Department of Health and Culture and the Department of Family and Employment. These two departments offer a wide range of health and social services in the municipality. As such, the socially marginalised men would at some point be in contact with one of these departments. The purpose of the support monitor group was to qualify my inquiries and curiosity, to give me insight into the municipal context, and to provide contact with gatekeepers. This was considered a strength because I was unfamiliar in different ways with the context of the municipality.

Substudy 1: The monitoring group provided contact information to four employees from two departments and one employee from an external organisation with a municipal cooperation agreement. Subsequently, the monitor group acted as gatekeepers to the field and the participating men. The gatekeepers all had professional backgrounds in either health or social work and had profound interests in the target group of this research.

Substudy 2: The monitoring group provided contact information to both employees and managers who already had contact with socially marginalised men or would like to have contact with them because of services that might benefit the socially marginalised men. Three from the monitoring group acted as both gatekeepers and participants.

SUBSTUDY 1 - MATERIAL AND METHODS

This section accounts for the study settings, access to the field, sample characteristics, the recruitment of participants, and methods used in substudy 1 (Paper I & II). All discussions regarding the strengths and limitations of the study are presented in Chapter 5 under Reflections on Research Process, Design, and Methods.

The Social Settings of the Fieldwork

The fieldwork was primarily carried out at two field sites: bench area A and bench area B (Appendix B). Three other benches in the city were also considered, but they were excluded because the users were primarily adolescents and outside the age limits. Another bench area was excluded because of modernisation. A third bench was excluded since the bench was in my own neighbourhood and was frequented by some of my neighbours. I would not have the opportunity to, as described by Madden (2010), really “clock off” from work, which would mean being ethnographic all the time. The distance to the benches gave me the opportunity to be positioned with an

outsider's perspective to the events and stories, which facilitates possibilities for critical reflection and questioning, which the scientific work required.

Bench area A was a collection of public benches. Some were sheltered under an open shed, which was situated in a green area in a community district under reconstruction. The users of the bench area were predominantly from the neighbouring area and of both sexes and various ages. Bench area A was situated in an area with numerous rental flats in varying conditions, and thus the municipal focus was on urban development. There were different types of social activities at the bench area such as discussions, maintenance of scooters, alcohol drinking, fights, and eating. The variation in activities was commonly accepted by the bench users. In addition, a code of conduct existed for this bench site. In order to manage the rules, every Sunday was officially designated as bully day. This day, the people who had violated the code of conduct could expect to be teased and mocked for their behaviour. Thus, people who attracted unfavourable attention during the past week had to accept nice bullying. Bullying seemed to serve as the background to the men's experiential perspective on manners. Varying participation in the social life was allowed, with no expectations. The daily conversations around the tables were free and about experiences with society or families. More private matters concerning personal problems or health problems were, by most men, not discussed in front of an audience but rather face to face or in smaller groups.

Bench area B was a collection of benches under a shelter situated in a deprived area in a green park located beside a worn-out block of flats, where one block operated as a social community with an employed social caretaker. The site was primarily visited by men of different ages, mostly from the neighbouring area and some from the nearby social community block. This bench was visited by males who drank alcohol at heavy levels during the day and at nighttime. Thus, the social life often ended up in a fight. This was of great frustration to the neighbours, and the police often were summoned. The

daily conversations were often conducted in a hard tone, and several of the men were influenced by AOD use, being clearly intoxicated, loudmouthed, and confrontational in their relations. The daily conversations around the table were free, and private matters were discussed openly.

Both bench sites were commonly visited by the community outreach nurse to aid individuals who were more marginalised than this study's targeted men in relation to health and/or social issues.

Time

The best times for getting access to the field sites were during the spring and summertime because of weather conditions. If the weather was rainy and cold, the men did not frequent the bench sites but rather sat at home or at a pub. For that reason, the fieldwork was conducted between April and August. Moreover, it turned out that the most appropriate time to visit the bench sites was late morning. This was because the men at that time were relatively sober, and the atmosphere was calm and relaxed, whereas later in the day, it could get chaotic and violent because of AOD use. During the fieldwork, I experienced a confrontational tone, with condescending and sexually discriminating calls at me. This created some troubling situations, where some of the men, in order to protect me, asked others to calm down and act properly, entailing a gloomy atmosphere, which is not unusual in research among marginalised population groups (Adler, 1990; Goldstein, 1990). To prevent myself from ending up in such situations, I chose to visit the benches at times where the men were most likely to be relatively sober.

Access to and Membership in the Men's Everyday Lives

Physical access to the field sites was obtained through gatekeepers (Atkinson, 2015). I was granted access to the bench sites; however, this did not entail access to the men's everyday lives. The real access was solely given by the

men granting me access to witness, participate in, and converse about issues that were reserved for more private relations (Atkinson, 2015; O'Reilly, 2012). This privileged access was based on some sense of membership, which needed to be negotiated (Atkinson, 2015). I negotiated the access every day at the bench sites by explaining my research and settling into a semi-overt role (O'Reilly, 2012).That way the men were aware that I was there because of a research study. Wiebel (1990) argues that establishing legitimacy for presence and intentions is important to evolve a successful relationship. This meant that I sat at the bench sites daily, talking to the men about daily routines and struggles, participating in their lives at the bench sites in a friendly and nonintrusive way.

As an example, after six weeks of daily visits at bench site A, a development in my access to the men's lives took place, which was due to a broken bicycle. The men often talked about the many competencies they possessed altogether. Competencies, they all argued, that society unfortunately did not need anymore. On several occasions, they asked me if I needed something repaired, perhaps on my bike. I considered their suggestion because my bike had broken pedals. This entailed several reflections for me. According to Corbin and Morse (2003), this was one of those situations where I had to make a decision that took into account the possible harm to the participants (Corbin & Morse, 2003). Was it ethically justifiable to get the men to change bike pedals when I could get them repaired elsewhere? Moreover, would this provide different insight to the men's social interactions? I discussed this with my supervisors and made the assessment that my intentions to change the pedals were to evolve a successful relationship. Also, it was a way to acknowledge the men and their competencies. I therefore brought the pedals. The following extract from the field notes elaborate what happened:

> I brought the pedals and tools and asked him (Jan) to help me. He smiled at me and said, "Yes, of course I will help you." I showed him the tools I brought. He looked at them. "A wrench," he said loud and smiled. "This is a women's tool." He tried to loosen one pedal with the

> wrench but did not succeed. He wanted to call Simon and ask him to bring proper tools, but as we spoke, Simon arrived at the bench site on his scooter. (. . .) After some discussions between Jan and Simon and three other men about tools, they agreed that Jan should take Simon's scooter and pick up some tools at Simon's place. But first, they had to unload the scooter because Simon had brought 24 beers and a radio. Jan drove off, and I sat down on one of the rocks, talking to the men about bicycles. When Jan returned, he started shifting the pedals and received constant and encouraging advice from the other men. It was not only Jan who repaired my bicycle; it was all five men present. They laughed and expressed small teasing comments to Jan. (. . .) After the repair, Jan said to me, "Here is my phone number. Call me if you need help again." One of the other men supplemented by saying, "We will always help you, and we have lots of different competencies."

This extract is an example of a negotiation of access and membership that turned out well. After this, I experienced a change in our relationship, exemplified by the fact that I was now offered a place to sit at the bench rather than on the stones beside the bench. This I perceived as a physical expression of another level of membership. Furthermore, the bicycle repair entailed that the men were concerned for me and my life and would try to take care of me if there was any tumult. Such sharing activities serving as one way of acceptance by the target group of the research is well known by other researchers (Baarts, 2006, 2015; Hastrup, 2010b; Wiebel, 1990).

Sampling

A combination of snowball sampling and purposeful sampling (Morse, 1991; O'Reilly, 2012) was used to apply a flexible sampling procedure. This procedure is well known from work with other unknown population groups that may be hard to reach (Watters & Biernacki, 1989). To address the study's aim, I sought to include individuals who were identified by gatekeepers as living in rented apartments and having low income, few social relations, health challenges, random or sparse contact with the municipal healthcare services, and engagements in risky health behaviours – as such, they may be conceptualised as socially marginalised. This is in accordance with the factors

mentioned by Benjaminsen (2015) that are associated with marginalisation: individual factors (control over own life, options available, autonomy); interpersonal factors (affiliation to social network, contact with others, social status, trust, entering communities); institutional factors (welfare payments, social and health services, organisation and coordination between services, disease prevention); and structural factors (labour market, income, housing conditions). Choosing men who lived in rented apartments was based on the fact that residents in general housing display higher morbidity rates, higher degrees of loneliness, and most often higher numbers of risky health behaviours (Jensen, Davidsen, Lau, & Christensen, 2018). Since more physical and psychosocial changes occur in midlife than at any other time, which can affect health-related quality of life and increase the need for healthcare services (Budetti et al., 2000; Wiltshire et al., 2009), the population criteria were limited to adult men ages 45–65.

Based on inclusion criteria as well as suggestions and access given by the gatekeepers, I contacted 24 men; 20 men (n = 20) out of the 24 were included. One of the men was subsequently excluded because he was outside the age limit. By spending time just being present and taking part in daily life at the bench sites and explaining the research, I received acceptance and trust as a participant at the bench sites. This is exemplified by the following field note:

> It seems like the time I have spent passing by the bench sites several times a week has been fruitful, as the men express how grateful they are for my visits and say that I am always welcome. Several compare me to the nurse from the outreach team. That makes me remember to be aware of my position, not acting as an outreach nurse, because that is not one of the positions I engage in. However, this is difficult because this also was the role that provided me access to the field.

Methodically, it was the outreach nurse's role that facilitated my access to the men. Because the men had confidence in the outreach nurse, this goodwill facilitated my ability to get in touch with the men.

My participation in daily life at bench sites A and B entailed that six (*n* = 6) additional men were included due to their interactions with me in the field. Based on the inclusion criteria, a total of 25 (*n* = 25) men participated in the study. Included participants in substudy 1 are provided in Table 3.

TABLE 3. INCLUDED PARTICIPANTS IN SUBSTUDY 1

	Through gatekeepers	Through the bench sites	In total
Included	19	6	25
Not included	5	1	6
In total	24	7	

The Participating Men

The men were a heterogeneous group. The average age of the men was 55 years, and they shared characteristics such as AOD use, varying health challenges –cardiovascular issues, chronic obstructive pulmonary disease, cancer, arthritis, and musculoskeletal challenges – and complex social challenges, including low levels of disposable income. All men received public assistance such as cash benefits (*n* = 11), unemployment benefits (*n* = 2), early retirement pay (*n* = 9), and wage subsidies (*n* = 3).

The men lived in rented apartments. Most of the men did not have formal education (*n* = 15) and had worked as unskilled labour, such as industrial workers and asphalt workers. Some had formal education (*n* = 10) (college diploma, bachelor's degree, skilled workers' certificate, etc.). Several of the men had been employed in one of the great industries in Aalborg Municipality, where drinking alcohol was a tradition and norm in the collegial gatherings at the workplaces. Most of the men socialised regularly in places such as the bench sites (*n* = 16), warm shelters (*n* = 2), men's shed (*n* = 2), and other places (*n* = 2), while some did not socialise regularly (*n* = 3). Most men were

single, and only two had romantic partners. Several had previously been in steady relationships, and some had children with their previous partners.

Participatory Observation

Participatory observations were carried out with different levels of participation (Madden, 2010; O'Reilly, 2012), balancing carefully between participation and observation (Wadel, Wadel, & Fuglestad, 2014). The participatory observations were conducted in the men's everyday lives in various locations, including public offices, park benches, and private spaces such as the men's homes. Participatory observations included interactions with peers, healthcare providers, and social workers. As a participant observer at two bench sites, I was able to develop an understanding of the men's perspectives both as individuals but also as part of the community at the benches. This approach seemed especially appropriate because it allowed me to explore the men's implicit understanding of health by following their doings. Their implicit understanding of health, according to Wackerhausen (1994), is not linguistically defined or articulated or even conscious to the individual but is still embedded in the way of action. Furthermore, the participatory observations enabled me to observe how health became a means of the men's everyday lives, which is in line with the WHO's health concept emphasising that health is also about well-being (WHO, n.d.).

In the beginning, I used an open strategy where I endeavoured to register as much as possible by asking the men descriptive questions (Hastrup et al., 2017) that were guided by the theoretical concepts of health, marginalisation and inequality as well as previous knowledge. The participant observations and interviews interacted mutually, qualifying the iterative process of the project (Agar, 1996). Later, my strategy became more focused on health and how the social structures of the group and the roles each person played were linked to their perceptions and behaviours about health (Madden, 2010).

The interviews and participant observations informed each other by emphasizing issues that I may not otherwise have found important. The interviews helped me sharpen the participatory observations, and vice versa. For example, I focused more on the social dynamics at the bench sites when people other than the participating men attended the benches. I realised that different groupings existed and that they had different ways of supporting each other. Moreover, an exploration of two bench sites, A and B, allowed for an awareness of unspoken practices and things taken for granted, such as bully day, as mentioned earlier, and how private matters were discussed differently at the two bench sites. The participatory observations were an expression of the etic perspective (Madden, 2010). The etic perspective is an external view of the meanings associated with real-world events (Olive, 2014; Roper & Shapira, 1999), such as when I tried to make sense of the men's everyday lives at the benches and how health was embedded in their everyday lives.

The material produced through the fieldwork consisted of field notes, photos, and reflections. Fieldwork was carried out in the period of April–August 2016 and included 200 hours of participatory observations among socially marginalised men. The relationships with some of the men became friendly, resembling companionship; however, some of the men were reluctant and dismissive, and I found note-taking to be intrusive to the relationships (Emerson, Fretz, & Shaw, 2011). Therefore, I chose not to write any field notes during participant observations, primarily because of the relationships I was developing with the participants. This is exemplified by the following field note extract:

> After we (the Outreach Team and me) left the place, we talked about being careful not to take forth my notebook because the men could be distrustful and wonder what I write about them. This may not be the way to create relationships with the men. We've talked about it before. Today I wondered if it was a good idea before I did it, and I would have liked to discuss it before I did it. But it was not a possibility. So, I decided to try. I made a sketch drawing illustrating the bench site and noted how many people were present. While I was drawing, I

> noticed that the men looked at me, but no one spoke to me like they usually did. I got quite nervous, and I quickly packed the notebook. I hope it does not destroy the trust the men have shown me. Nonetheless, the drawing has been a big help to me afterwards in reconstructing my memory.

Afterwards, I did not challenge this again and chose not to use the notebook visibly. This meant that I jotted participatory field notes (Madden, 2010) in a notebook after each observational period as a reminder for when I wrote up consolidated field notes (Madden, 2010) at the end of each period. I took photos that did not portray the men but solely the bench sites, which were used exclusively to support my reflections because I refrained from note-taking at the field sites.

In sum, one of the strengths of participatory observation is that it is the social action that is the source of the ethnographic material. It produces knowledge of the complexities of meaning formation and social practices (O'Reilly, 2012) which is in line with the pragmatic assumption that knowledge is socially constructed (Brinkmann, 2006; Morgan, 2014; O'Reilly, 2012). However, using this method was not without limitations, which will be elaborated on in Chapter 5 under Reflections on Process, Design, and Methods. Moreover, dependability as part of achieving trustworthiness in this research was attained by keeping records of the raw data, field notes, transcripts, photos, and sketches, which helped me systemize, relate, and cross-reference the material as well as ease the reporting of the research process – understood as creating a clear audit trail (Miles, Huberman, & Saldaña, 2014).

Interviews

The interviews provided an opportunity to obtain emic data (Madden, 2010) from the men's perspectives. In this study, the ethnographic interviews (n = 25) ranged on a spectrum from less to more formally structured (Madden, 2010; O'Reilly, 2012). The different men and the different situations I entered required different ways of dealing with the interviews. Thus, some

conversations that I had planned as more formal became unstructured and free-floating because it was what suited the interaction best. In other situations where I thought the interview could be unstructured, the men asked for specific questions and requested that the tape recorder be up and running. That way the interviews were characterised by being collaborative, guiding, and flexible (O'Reilly, 2012), which correlates with the pragmatic perspective that knowledge is socially constructed and is a representation of the social practice between the participants and researcher (Whyte, 1999). I also participated in conversations that took place between men while sitting at the bench sites. In such situations, it could be difficult to encourage the men to talk about a specific subject when they were together. However, I attempted to make this an opportunity to observe the dynamics of the group instead. I observed how the men shared ideas and how their ideas became more focused in their interactions. I also experienced how such opportunistic group interviews (O'Reilly, 2012) became potentially useful for exploring the study's aim. As an example, there was a group of men who shared similar experiences of healthcare professionals who talked *at* them, not *to* them. These men became franker and more open in the opportunistic group interview, allowing me to gently guide the conversations, so I pursued this study's aim by asking them to elaborate on their experiences. At other times, it was possible to drop a comment or question to the men about something that I might have heard about from other participants – for example, the idea that all men over 50 years should have a forced health check.

The more formal interviews had a series of key topics to pursue (Madden, 2010; O'Reilly, 2012) and were primarily conducted in the men's private homes, lasting approximately 30 minutes to 2 hours (Appendix C). Being invited into the men's home allowed me to contextualise what I experienced in the interviews or in the observations at the bench sites. For example, several of the men stated that their lives were chaotic, which also affected their home environments. The formal interviews were all audiotaped and

transcribed verbatim. The key topics were initially constructed around four themes: health, health perceptions, health behaviour, and health literacy, guided by the main theoretical concepts, previous knowledge and experiences from the participant observations. The interviews made me explore the men's explicit health perceptions, which, according to Wackerhausen (1994), may be linguistically displayed inconsistently to the individual's implicit health perceptions. This suggests that we can have a health perception that we are not aware of, though it is manifested in our daily life actions.

A fifth theme, social network, was added after an initial analysis of the material from the first eight interviews and from the fieldwork, as an example of the iterative process (O'Reilly, 2012). As such, seven of the men were interviewed again based on the fifth topic.

The interviews and the participant observations were mutually qualifying to the iterative process of the project, and thus they interacted mutually (Agar, 1996). The interviews gave insight into individual experiences and explanations of social happenings (Baarts, 2015), which elaborated on situations I had observed at the bench sites. Furthermore, the participant observations made it possible to support the qualitative interviews in the way that the questions became more relevant (Hastrup et al., 2017) to exploring the men's health perceptions. Participant observations highlighted issues relating to the empirical context that otherwise would not have been mentioned in the interviews because they were taken for granted by the men since these issues may have been an overlooked part of their everyday lives.

The material produced through the interviews consisted of records of conversations, interview transcriptions, and notes taken during or after the interviews. The notes mostly concerned the social context, nonverbal communication, context of the interviews and concepts, and reflections or phrasings I found worth pursuing later. After each interview, I wrote notes

about the course of the interview and other general comments about the interview, unresolved matters, and general thoughts (O'Reilly, 2012).

For a brief summary of the use of interviews in substudies 1 and 2, I refer to the closing remarks on interviews in the section on substudy 2.

SUBSTUDY 2 - MATERIAL AND METHODS

This section accounts for access, sample characteristics, recruitment of participants, and methods used in substudy 2 (paper III). All discussions regarding the strengths and limitations of the study are presented in Chapter 5.

Sampling and Participants

Through purposeful sampling, 22 (n = 22) managers and employees were included in substudy 2. This included eight participants from the Health and Culture Department, divided into four managers and four employees. There were eight participants from the Family and Employment Department, divided into four managers and four employees. Late in the interview period, I became aware that outreach health services were offered to marginalised citizens in a third department (the Elderly and Disability Department), from which I had no planned inclusion. This was an example of the ethnographic ideal of how the method always bends in the direction of the material (Hastrup, 2010a). I investigated and got in touch with this department and employees who provided the outreach services. As a result, two employees from the Elderly and Disability Department participated in substudy 2. In addition, two employees and two managers from organisations with municipal cooperation agreements, such as an organisation that administrated apartments for rent, and the Social Emergency Centre were included. The total sample consisted of employees who were health professionals, social workers, or social educators and managers with backgrounds in health or social work. Three of the included participants were part of the monitoring group, and they acted as

both gatekeepers and participants. Inclusion criteria aimed at obtaining equal representation from the management and the employee levels to gain insight into both the organisational decision-making processes and the practical execution and understanding of the organisation's structure in relation to supporting socially marginalised men's healthcare needs.

Interviews

The interviews (*n* = 21) whereas one was an interview with two participants in substudy 2 were formal and had a series of key topics to pursue (Madden, 2010; O'Reilly, 2012) (Appendix D). They were conducted at the workplaces of the municipal employees due to the focus on experiences and perceptions related to their work in the municipality. The interviews lasted approximately one hour. Interviews were recorded and listened to several times while reflections and quotes were being transcribed.

The key topics were initially constructed around accessible and relevant municipal health services for the men, the interviewees' involvement in health and social services offered to the men, the organisational framework for these services and cooperation, experiences with proactive efforts, and consistency between health services in different departments. As with the interviews with the men, these interviews provided an opportunity to obtain emic data (Madden, 2010) from the municipal employees' perspectives. The interview questions were supported by knowledge from the participant observations and interviews from substudy 1. Thus, material from substudy 1 contributed with issues relating to one empirical context, allowing an exploration in another empirical context (Hastrup et al., 2017).

One of the interviews turned out differently than planned. When I arrived at the interview setting, the participant had invited a colleague, and the interview turned out to be an interview where both participated. This turned out well because they supplemented each other's narratives, as described by O'Reilly

(2012), in a way where they openly discussed challenges in working with citizens with complex needs. This experience made me reflect on the fact that I could have planned focus group interviews (Halkier, 2016) with employees and managers rather than single interviews, because focus groups are considered beneficial when exploring social group interpretations, interactions, and norms (Halkier, 2016). Reflections thereupon will be elaborated on in Chapter 5, under Reflections on Process, Design, and Methods. However, because this was one of my last interviews, it was too late to change the methods.

The material produced through the interviews consisted of records of conversations and notes taken during or after the interviews. These notes are mostly concerned with the social context of the interview and concepts, reflections, or phrasings I found worth pursuing later, as well as general thoughts (O'Reilly, 2012).

In sum, the use of individual interviews in both substudy 1 and substudy 2 seemed well chosen; the single interviews are situated, contextual, and relational (Hastrup & Hastrup, 2009), whereby knowledge is socially constructed, which is in line with the fundamental pragmatic perspective (Brinkmann, 2006; Morgan, 2014; O'Reilly, 2012). However, using focus group interviews might have provided data on social group interpretations, interactions, and norms (Halkier, 2016), which will be further discussed in Chapter 5 under Reflections on Process, Design, and Methods.

CONSIDERATIONS OF THE RESEARCHER ROLE

Throughout this study, reflexivity was used as a method to reflect on my researcher role (Madden, 2010). This was essential because of the myriad limitations and advantages associated with humans studying other human lives (Emerson et al., 2011; O'Reilly, 2012). Considerations of the researcher role have been present throughout the study and I have regularly revisited

theoretical formulations on research positioning (Sandelowski, 1993) as will be seen in this section.

Through the different methods used, both emic and etic perspectives (Madden, 2010; Roper & Shapira, 1999) broadened the understanding of the men's perceptions of health and their health behaviours as well as the municipal employees' understandings. By finding the emic meanings and views of the men and employees and my etic interpretations of these meanings, I have constructed an understanding that takes both perspectives into account and is thus contained well within the pragmatic perspective. This interplay of emic and etic perspectives permits the deep and rich insights associated with ethnography (Roper & Shapira, 1999).

As a researcher, my involvement in the field was always positioned because observations took place from a specific position. That means that some parts of the social world are seen with more analytical clarity than other parts of the world (Hastrup, 1992; Tjørnhøj-Thomsen & Ploug Hansen, 2009). For example, in substudy 1, my understanding, involvement, and acceptance of the men's stories enabled the fieldwork and ethnographic interviews to have epistemological consequences. In the meetings with the men, where some of them in the past had existential experiences with serious consequences for their lives, I found myself constructing interpretations of their situations. This included my hope for a better life for the men and a wish to take some of the blame and shame away. Therefore, I tended to present them as struggling individuals, which might awaken sympathies in others such as researchers or readers. Furthermore, the appreciative relationship with the men entailed that I felt a moral responsibility to speak their case and take care of them. My moral responsibility seemed to influence the direction of the men's stories. I started making accounts where the men appeared vulnerable, establishing an understanding where the municipality became co-responsible for their health situations. However, the men were not struggling individuals in a cruel world ruled by politics and economics. The men never talked of themselves like that.

Some of the men described themselves as marginalised; others would never do that, even though they, in a condescending voice, referred to themselves as “someone like me with,” implying that they were different than others. This is, to some extent, similar to findings in a recent Danish survey that found that among socially marginalised, especially in groups of 35-to-55-year-olds, the number has increased of people who describe themselves as socially marginalised (Rådet for Socialt Udsatte, 2018). My interpretation was influenced by my embedded middleclass norms and I was affected by my background as a registered nurse working primarily at emergency units, which largely leaned on biomedical knowledge. In several discussions with my supervisors, I became aware of my own embedded preunderstandings. My own preconceptions about health seemed to impact the material generated (Kirkevold & Bergland, 2007). Through my reflections, I became aware that I, at a certain point, merely was reproducing my norms and views, which, for a short period, obscured the realisation that the men all shared the same dream, which was about living the good life without bodily or mental limitations.

During the fieldwork, I became deeply engaged with the men and their stories. The conversations and the confidentiality between us provided insight into very personal and profound opinions and experiences. Such conversations can act, as Fog (2001) denotes it, as a Trojan horse. Thus, the men were at risk of being seduced into an openness they really did not have an interest in expressing. At the same time, it was redeeming for them because the conversations led to processing and insight (Fog, 2001). However, continuing research after personal participation and shared realities requires an analytical distance. Madden (2010) describes this as “close, but not too close.” This refers to the fact that a researcher may get close yet needs to step back before a social immersion (Madden, 2010). I got close and involved in the men’s everyday lives without taking on the behaviours the men exhibited; for example, I did not pick up their habits of AOD use. However, “close, but not too close” requires a delicate balance. There is a risk that the men did not feel

recognised, because by saying “No thanks” to something that was a big part of their everyday lives, I did not acknowledge their way of life and thereby remained an outsider. Consequently, I made a lot of effort to meet the men with recognition, understanding, and acknowledgement of their way of living. In showing such commitment, I prompted the men to eventually have trust in me and to tell their stories.

Throughout this study, it has been important to reflect on how my previous work experience from clinical nursing, teaching, research, and working with marginalised citizens influenced this research. I previously worked as a nurse among socially marginalised citizens and was consequently familiar with the role as a nurse and as a researcher. However, I was unfamiliar with these roles in the context of the municipality and at street level. Wedel et al. (2014) argue that it is possible to mobilise a larger number of roles if research is conducted within one’s own culture rather than within a culture that is dissimilar. Because the roles were partly familiar to me, it was possible for me to formulate questions that varied in content (within the key topics to pursue) and the way I asked the questions. However, as Wadel et al. (2014) point out, by jumping between different roles during a conversation, there is a risk of overlooking nuances and details that may be important in relation to producing material. For example, I found it easier to talk to employees who, like me, were health professionals, because we shared common professional points of view and common language. However, in these situations, it was easy for me to lose track and forget that I was doing research and exploring the actor’s different perceptions. In situations with employees from other occupational fields, I mobilised my researcher position with an attempt to obtain more credibility in asking questions and having a conversation about fields that might be unknown to me. However, eventually I found that the role that led to the best conversations was in the situations where I succeeded in being explorative and mobilised the position as an apprentice (Wadel et al., 2014). However, it involved a constant reflexivity over my own role and position

(Emerson et al., 2011; Madden, 2010). I deliberately activated reflexivity through various readings of fieldwork and ethnographic methods and through discussions with peers and my supervisor team on events in the field and field notes and texts I had written. Eventually, I seemed to find a balance where I was able to explore the employees' experiences and perceptions while taking my previous experiences as a nurse and researcher into account.

3.3 ANALYSIS

This section describes the common features of the analyses in substudies 1 and 2, respectively. This is followed by a synthesis of findings.

I chose thematic analysis because of its theoretical freedom, which can be used across a range of epistemologies (Braun & Clarke, 2006). The analysis in each substudy was an iterative process (Morse, 2015; J. Morse, Barrett, Mayan, Olson, & Spiers, 2002). Through the coding process, the research questions evolved and were linked to the abductive reasoning known from pragmatism (Atkinson, 2015, 2017). Abduction, which is a combination of induction and deduction, makes it possible to perceive connections on a deeper level and reveal the underlying dynamic processes and phenomena in practice (Eriksson & Lindström, 1997). Thus abduction assumes extensive familiarity with existing theories at the outset and throughout every research step (Timmermans & Tavory, 2012). Abduction is thereby like the concept of iterative-inductive, which is used by O'Reilly (2015), who argues that it is impossible to do research with no knowledge at all. Yet according to O'Reilly (2015), one should not stay too long in the literature – you need to go out there and explore the world too. This means that when I encounter a new observation or event, I ask what this is an expression of and make different hypotheses that might represent or illuminate some underlying patterns. Then I apprise which one fits best into the existing world. This meant that I as described by O'Reilly (2012) had an eclectic approach to theory where theory was only useful inasmuch as it helped to make sense of the world. Such

theoretical openness to the analysis was chosen because I wanted to conduct an analysis without knowing in advance what, for example, health looked like for the socially marginalised men in this study. I have been careful not to make theoretical concepts prominent in the analysis. However, it is important to clarify that the analysis process was supported by robust analytical ideas that stemmed from main theoretical concepts (Atkinson, 2015; O'Reilly, 2012) alongside previous research contributions (Sandelowski, 1993) thus acting as guiding ideas for the development of my analytical thinking in the analysis. The overview of this literature was presented in Chapter 2.

Common Features of the Analyses in Substudies 1 and 2

The empirical materials in substudies 1 and 2 were analysed separately and involved three concurrent activities: (1) data condensation, including processing and preparation of the material, first cycle coding, and second cycle coding; (2) data display; and (3) drawing and verifying conclusions (Miles et al., 2014).

Substudy 1

The objectives were to explore health perceptions and health behaviours influencing overall health among socially marginalized men who seem to not benefit from existing healthcare in a large Danish municipality. The objective was also to explore the factors that influence health-related help-seeking behaviour among socially marginalised men between 45 and 65 years of age in a large Danish municipality. The first activity in the analysis process included processing and transforming the material, and the interviews and observations were analysed together. Field notes were converted into expanded write-ups, and audiotaped interviews were transcribed verbatim. NVivo 11 software (Kjeldsen, Bøgh Andersen, & Binderkrantz, 2016) was used for managing, maintaining, storing, and coding the material.

The next step involved first cycle coding, using descriptive and in vivo coding (Miles et al., 2014). In total, 69 codes were assigned, including descriptive codes, such as *everyday life* and *significant experiences*, and in vivo codes, such as *taking care of myself* and *who I talk to when I feel bad*. Based on patterns of behaviour, events, or activities (Agar, 1996), these codes were summarised into coded segments (Miles et al., 2014). This led to seven segments of material: *everyday life challenges*, *accept and respect*, *normality*, *a different kind of normality*, *the importance of the bench*, *network and being together*, and *it feels good when I*.

The next step, second cycle coding, entailed grouping the summarised segments; thus, some went on to form early themes. This process continued until a refinement of the themes was done; some turned out not to be themes because there was not enough material to support them (Braun & Clarke, 2006; Miles et al., 2014). I ended up with two candidate themes: *priority of health in everyday life* and *influential factors on health-related help-seeking.* To further refine and structure these large themes, subthemes were added, which is illustrated in Table 4.

TABLE 4. OVERVIEW THEMES AND SUBTHEMES IN SUBSTUDY 1

Theme	Subthemes	Paper
Priority of health in everyday life	• Health as a feeling of well-being • Health as a feeling of belonging in social relations • Health as a competency to be active • Health as a competency to manage everyday life	I
Influential factors on health-related help-seeking	• Men's knowledge, perceptions, and previous experiences of health services • Being talked to rather than being talked at • The roles of others in health-related help-seeking • Gender, masculinity, and health-related help-seeking	II

Substudy 2

The objective was to explore municipal employees' experiences and perceptions of how to support healthcare needs among socially marginalised men between 45 and 65 years of age who currently seem not to benefit from municipal healthcare services in a large Danish municipality. The first activity in the analysis process included processing and transforming the material. The audiotaped interviews were listened to several times while reflections and quotes were being transcribed. NVivo 11 software (Kjeldsen et al., 2016) was used to manage and maintain order in the material.

The next step involved first cycle coding using descriptive coding (Miles et al., 2014). In total, 30 codes were assigned, including descriptive codes, such as *what comes first—health or social needs* and *it is a shared responsibility*. These codes were summarised into coded segments (Miles et al., 2014). This led to six segments of material: *cooperation across departments*, *difficulties in attracting socially marginalised men*, *social or health problems first?*,

expectations to each other, *a shared and important assignment*, and *lots of relevant health services offers*.

The next step, second cycle coding, entailed grouping the summarised segments; thus, some went on to form early themes. This process continued until a refinement of the themes was done; some turned out not to be themes because there was not enough material to support them (Braun & Clarke, 2006; Miles et al., 2014). I ended up with one candidate theme: *organisational structures in the municipality*. To further refine and structure this large theme, subthemes were added, which is illustrated in Table 5.

TABLE 5. OVERVIEW THEME AND SUBTHEMES IN SUBSTUDY 2

Theme	Subthemes	Paper
Organisational structures in the municipality	• Various fields of responsibility • Various experiences and practical approaches to support health • Supporting health among socially marginalised	III

For substudy 1 and substudy 2, the activity of data display involved methods of analysing the material in progress and an explanatory matrix, which served as an initial answer to the findings (Miles et al., 2014). The activity of drawing and verifying conclusions involved triangulation of material – such as the triangulation of participatory observations and interviews, and researcher triangulation involving discussions with supervisors about my interpretations – which was consistent with what the material showed, and helped increase trustworthiness through credibility (Miles et al., 2014).

Synthesis of Findings

The overall aim of this PhD research was to explore the socially marginalised men's experiences and perceptions of health in the context of their everyday lives. The aim was also to explore municipal employees' experiences and

perceptions of how to support socially marginalised men's healthcare needs and contribute with perspectives and clarification of possible challenges.

The findings from substudies 1 and 2 were synthesised, and the aim of the synthesis was to uncover factors that had not been fully described before and to strengthen the findings from substudies 1 and 2. This would enable organised and rich descriptions of common themes and their relationships (McNaughton, 2000) and produce new and integrative interpretations of findings (Finfgeld, 2003), thereby building a foundation that provides evidence for future exploration in this area and guides future studies on how to implement this study's knowledge.

This synthesis was inspired by Miles et al.'s (2014) and McNaughton's (2000) analysis strategies. The synthesis consisted of first and second cycle coding, and the procedure was as follows: The Findings sections of each paper and the content were coded to designate portions of the text (McNaughton, 2000) relating to socially marginalised men's health perceptions, experiences, and needs as well as the municipal employees' experiences. A starting list of codes was developed to produce broad categories and to organise the material with the purpose of facilitating the synthesis. I coded meaningful features of the material systematically across the substudies (Miles et al., 2014). A list of codes from papers I–III are provided in Table 6.

TABLE. 6. CODES FROM PAPER I–III

Paper I	Paper II	Paper III
• Well-being • Belonging • Being full • Participation in everyday life • Ability to manage everyday life • Social relations • Social norms • Distress • National health recommendations • Emotional support	• Human decency • Respect, recognition, acceptance • Integrity • Unmet health needs • Self-medication • Masculine ideals • Supportive social networks • Unified system • Lacking knowledge on municipal healthcare services • Outreach	• Programs promoting collaboration • Feeling of uneasiness • Integration of services • Outreach • Proactive approaches • Interdisciplinary cooperation • Competencies • Policy sectors • Good relationships were pivotal • Pursuing health as a shared objective

Based on patterns, events, or activities (Agar, 1996), these codes were summarised into 15 coded segments (Miles et al., 2014), which led to 15 segments of material. This summary features the relationships identified from the codes, including considerations and reflections on how they may be combined to form an overarching theme. A list of segments of material is provided in Table 7.

TABLE 7. SEGMENTS OF MATERIAL

Segments of material
• Health concepts of the men are related to emotional states • Health is about managing everyday life • Social relations/networks influence on everyday life • The men want to be accepted • The role of masculinity • The men have complex needs—social and health needs • Self-medication as a means to manage everyday life • Think of the system as a unified system • Competencies—specialised and broad • Interdisciplinary cooperation is crucial • Varied social and health interventions are already offered • Working across boundaries is challenging • Lack of knowledge about each other's services and working methods • Complex tasks such as how to get in touch with the men

The final stage of condensation of the material, second cycle coding, entailed grouping the summarised segments into themes (Miles et al., 2014). In this stage, I visualised themes by using a mind map, writing down the segments on note cards, and playing around with organising them into theme piles. I ended this stage with two candidate themes and five related subthemes, as displayed in Table 8.

TABLE 8. THEMES

Themes	Subthemes
Forming constructive relationships	• Navigating the healthcare system • Supporting men's peer support • Gender and masculinity
Comprehensive competencies	• Flexibility and deviation from standard practice • Relational competencies and an outreach approach

These two synthesised themes, including subthemes, comprehend the relationships between the two substudies regarding the men's and employees'

perceptions and experiences related to health, which is elaborated on in Chapter 4: Findings.

3.4 ETHICAL CONSIDERATIONS

The study was approved by the Danish Data Protection Agency (2018) (Project ID number FOU-PHD-003) to ensure that the research was ethically sound and that the rights, safety, and well-being of the participants were protected (Appendix E). To ensure credibility, integrity, and thereby quality in the research, common principles and standards of good scientific practice have been followed. For that reason, the North Denmark Region Committee on Health Research Ethics was notified about the study and confirmed that the project could be initiated without any further clarification or requests since the project was not a biomedical project that involved human biological material (Appendix F).

As a researcher, it was my responsibility to take ethical considerations into account while designing and conducting research (Atkinson, 2015; O'Reilly, 2012). For this reason, the study was carried out in accordance with the Code of Ethics of the World Medical Association (American Anthropological Association (AAA), 2012; Ministry of Higher Education and Science, 2014; WMA, 2013). In Denmark, the regional ethics committees and the Data Protection Agency are responsible for approving health research.

Written and verbal information about the study were provided to the men and municipal employees (Appendixes G & H). The information sheet given to the men was prepared in cooperation with the gatekeepers and one of the participating men. They argued that several of these men had previous experiences which made them sensitive and would deter them from participating in this research. They recommended, among other things, that the letter should not include the term *marginalised* and that it should be written

as concisely as possible. Their experience was that it was better to give the information face to face, which I did. To accommodate the processual ethical research requests (Johansen, 2017), all men in substudy 1 were asked to give their consent indicating their interest in participating in the study, which all did in writing or orally (Appendix I). During the fieldwork, information about the study was repeatedly provided verbally as well as on written information sheets given to the included men, and their consent was continually negotiated (Boulton & Parker, 2007) as a trusting relationship was formed and evolved. In substudy 2 all employees indicated their interest in participating in the study by giving written consent (Appendix J).

The other users of the bench sites were informed of the research and my role at the bench. This, however, was a complex situation because bench users stepped in and out of the setting, which called for particularistic research ethics (Johansen, 2017). This includes combining knowledge on the actual empirical context, intuition, and impressions with my moral responsibility and humanity (Miller & Boulton, 2007; Tjørnhøj-Thomsen & Ploug Hansen, 2009) to protect the field-site users' integrity and identity. Based on this, I decided to perceive their presence at the bench as a commitment to participation because they chose to stay in the relationship even though they could have chosen to leave the bench. However, as described by Hastrup (2009a), a constant situational assessment of the situation is what constitutes the ethical reflection and is part of the scientific practice (Hastrup, 2009b).

4 FINDINGS

In the following section, main findings from substudy 1 (paper I & II) and substudy 2 (paper III) are briefly summarised. This is followed by a synthesis of findings from substudies 1 and 2, culminating in a new interpretation to comply with this study's overall aim.

4.1 MAIN FINDINGS FROM PAPER I

Paper I demonstrates variations in health perceptions among the men. Overall, the findings demonstrate that health is perceived as related to the ability to participate in daily life activities such as getting around effortlessly and the ability to work. Alcohol use appears to be part of a complex approach to managing everyday life, including various personal physical and mental health challenges and admission to social networks. Thereby, the complexity in the men's lives seems to influence their health choices in everyday life. The interaction between peers seems crucial because it involves strong ties of loyalty and emotional support, which is coincident with complying with the social norms regarding AOD and cigarette use. As such, the men's health perceptions related to well-being and belonging to a network coexist with their AOD use. At the bench sites, a common health understanding is established that is considered acceptable within the context of the bench's social community. The men recognise that there are other ways of defining and living in a healthy way without perceiving their way of life as unhealthy, because it seems normal to them and further contributes to their feeling of belonging. It can be argued that the men perceive their lifestyle as healthy because their health behaviours are in line with the framework of the existing view of normality, which may influence which choices are acceptable and thereby justify the men's health perceptions and behaviours.

4.2 MAIN FINDINGS FROM PAPER II

Paper II demonstrates complex health-related help-seeking behaviour with interacting social- and health-related conditions. The men wish to be treated with human decency, respect, recognition, and acceptance of their integrity. However, several of the men choose not to seek health-related help since they have previously walked away from health services with their health issues unresolved. The previous experiences entailed an insecurity as to whether their needs would ever be met by any healthcare services. Consequently, they debate whether it is worth seeking help, which further leads some men to self-medicate by using cannabis or alcohol, for example, to reduce pain. The findings reveal how different social contexts and social networks influence health-related help-seeking. Some men received support from peers at the bench, others from close family members, and others from the municipal Outreach Team. The men do not distinguish between employees from different services but have a common understanding of a unified system. However, the contact the men have with the municipal Outreach Team differs from other healthcare contact because the Outreach Team seems less focused on changing health behaviours and more focused on remedying current health problems based on knowledge of each individual man's health challenges and life situation.

4.3 MAIN FINDINGS FROM PAPER III

Paper III demonstrates that supporting socially marginalised men's healthcare needs across policy sectors are challenging. A common stand is that socially marginalised men had complex healthcare needs and would benefit from the integration of social care and healthcare. To accommodate this interdisciplinary cooperation across policy sectors is crucial. However, organisational structures such as functional differentiation with specialisation, division of labour, and increased autonomy seem to challenge cooperation unless previous cooperation has been performed. Thereby, integration of

services and interdisciplinary cooperation across policy sectors seems to depend on personal interorganisational conditions, such as personal knowledge, rather than programs promoting collaboration. This seems to have an unintended effect because it challenges the integration of social care and healthcare services. Supporting socially marginalised men is an important yet complex task, especially regarding how to get in touch with the men. Some departments have canvassed, with positive results in attracting hard-to-reach citizens (not solely socially marginalised men). This approach, however, does not appeal to other departments, as it produces an uneasiness among the employees and seems to require competencies not covered by their core competencies and responsibilities. As such, it seems like broader competencies yet specialized may be needed when working with socially marginalised men.

4.5 SYNTHESIS OF FINDINGS

The aim of this synthesis was to explore the findings in substudies 1 and 2, identifying a new interpretation to comply with this study's overall aim. This synthesis was guided by Miles et al. (2014) and McNaughton (2000). The two synthesised findings – forming constructive relationships and comprehensive competencies – and their five related subthemes comprehend the relationships between the two substudies and are briefly elaborated on in the following section.

Forming Constructive Relationships

Navigating the healthcare system

Forming constructive relationships concerns building and maintaining trusting and appreciative relationships, which the men had varied experiences of yet emphasised as important. The ideal in the Danish welfare system is equality in health for all citizens; however, it seems that this study's socially

marginalised men are at the margin, because the men's health perceptions and health behaviours seem different from the objectives, rationales, and conditions of practice in the municipality and overall healthcare system. The men's expectations and experiences are often woven into complex relationships, in which health challenges cannot be separated from their social everyday lives. The differentiated healthcare system, including specialisations, seems irrelevant to the men, as they perceive healthcare as a unified system delivering a variety of services. This may explain their lack of knowledge about the municipal healthcare services and indicate challenges in navigating the overall healthcare system as well as a need for professionals to gain insight into the complexity that characterises socially marginalised men's health and everyday lives.

Supporting men's peer support

Supportive relationships among the men seemed crucial to their well-being and feeling of belonging. From the men's perspectives, the bench communities served as a resource and provided peer support. However, from the perspectives of a health professional, this context may be perceived as encouraging risky health behaviour, indicating that values associated with reducing risky health behaviours are not immediately appreciated by the men. The men have, in many ways, adapted to the societal reality of their everyday lives, for which reason it may be difficult for outsiders such as health professionals to identify and understand the connection between their social lives and health behaviour unless they form constructive relationships with the men and gain insight into their lives. Health professionals should emphasise forming constructive relationships with the men to achieve comprehensive insight into the everyday life situations of the men and to encourage men's peer support.

Gender and masculinity

The synthesis showed that gender and masculinity were both important, but in different ways. In relation to the men's perspectives, gender roles and masculinity seemed to influence men's decisions regarding help-seeking, seemingly because they perceived that they, as males, should appear to be independent, self-reliant, strong, robust, and tough by not openly admitting health challenges initially. The men expressed and showed that they were shaped by the culture from their working lives and from their upbringings, both of which encouraged masculine characteristics. This indicates that being a man was associated with a particular behaviour in relation to health, in which it was expected that they would not complain but rather "take it as a man." However, the findings also revealed how the men used peer support at the bench sites by sharing personal stories about their situations while receiving advice and ideas on how to manage them. This may indicate that gender roles and masculinity are not stand-alone variables that can serve as explanations for health perceptions or the engagement in risky health behaviour. The picture seems complex, indicating a need to explore the men's contextualised understandings of their health, health-related help-seeking, previous experiences, and significance of their social networks rather than building on gender stereotyping. Findings support the fact that a constructive relationship is essential to explore what is at stake for the individual man and to support his health. In relation to the municipal perspective from the employees, there seemed to be a big difference in whether they focused specifically on gender and masculinity. This applies both to citizens in general and to marginalised citizens. This difference was apparently related to the overall policy in the specific policy sector, which gave varying perceptions of the importance of gender-specific services.

Comprehensive Competencies

Flexibility and deviation from standard practice

Comprehensive competencies cover being flexible in terms of openness, respect, and tolerance towards life choices among socially marginalised men in order for health professionals to engage in forming constructive relationships. Based on the perceptions and experiences of the socially marginalised men and the municipal employees, findings emphasise that the professional work often requires flexibility and deviation from standard practice because of a convergence between men's health and social challenges. However, employees experienced insecurity if the men's problems and need for support were outside their core tasks and located in a different department. This may suggest that collaboration across policy sectors is crucial to make integration between social- and health-related tasks possible. Consequently, and based on the men's perspectives and perceptions of health and their previous experiences, professionals need to display flexibility creatively through spontaneity and adaptability, among other things. Even though not all men are interested in reducing or ceasing their AOD use, they still want treatment for high blood pressure. Thereby, the men may be at risk of being excluded from service if they do not cease their AOD use. This may indicate a need for an approach that focuses on reducing harmful effects by taking the men's entire lives and social situations into account and supporting them with the challenges they may face.

Relational competencies and an outreach approach

Knowledge and understanding of the men's complex life situations are of great importance to the relationships between the professionals and the men, and it may be relevant for health professionals to meet the men in their usual environment. The men would find such accessibility important, resulting in a greater confidence in the professionals' commitment. However, this study's findings show that an outreach approach is a time-consuming process that requires patience and time for repeated visits and is a practice that does not appeal to all professionals. This indicates that because the men actually appreciate this approach, which differs from their previous healthcare

encounters, it is important that employees using this method are also confident in the approach. However, findings indicate that several of the employees who may have participated in this approach lacked mentoring in working with socially marginalised citizens. This may suggest a need for attention given to the social networks across policy sectors so that various sectors can support each other.

5 DISCUSSION

In this section, the synthesised findings from substudies 1 and 2 are discussed in light of the overall aim of this thesis and in the context of previous research. The synthesized findings govern the discussion. The scientific rigour and limitations of the research process, design, and chosen methods are subsequently reflected upon.

5.1 DISCUSSION OF FINDINGS

The overall aim of this PhD research was to explore the socially marginalised men's experiences and perceptions of health in the context of their everyday lives. The aim was also to explore municipal employees' experiences and perceptions of how to support socially marginalised men's healthcare needs and contribute with perspectives and clarification of possible challenges.

FORMING CONSTRUCTIVE RELATIONSHIPS

Navigating the Healthcare System

The findings of this research suggest that it is important that health professionals who, through their work, encounter socially marginalised men make an effort in forming constructive relationships to learn about the men's everyday life challenges. Supporting the men's health needs seems not to be a "one size fits all" solution, which is supported by other studies (Brüne, Lisby, Kjeldsen, & Elsborg, 2018; Hjelmar et al., 2014; Sundhedsstyrelsen & COWI, 2015). Special conditions in the men's everyday lives convey a complexity in supporting their health needs, since they seem to involve an integration of social care and healthcare services. This integration must be coordinated across organisational and professional boundaries to benefit the men. The increasing complexity in the healthcare system, partly because of

specialisation and fragmentation of services, might influence this effort (Brostrøm, 2017; Holt, Carey, et al., 2018) negatively or positively.

Forming constructive relationships allows for an exploration and possibility of supporting the complex needs these men have. A substantial portion of the Danish population perceives difficulties related to understanding health information and engaging with healthcare providers, and a socioeconomic gradient in health literacy has been observed (Bo, Friis, Osborne, & Maindal, 2014). Different services may be located in different parts of the overall healthcare system, which adds further complexity because socially marginalised people find it difficult to understand and navigate the healthcare system (Brostrøm, 2017; Pedersen et al., 2017; Toke & Vestergaard, 2017). This is worrying from a public health perspective and may entail inequality in health because it increases the individual demands of taking responsibility for one's own health, which may be difficult for many citizens (Kristensen et al., 2016). Individuals facing such complexity may benefit from constructive relationships with professionals who consider the men's everyday lives and previous experiences with the system in order to accommodate the men's complex care needs, which often require integration of healthcare and social services.

Organising healthcare services in a way that may be more attractive and supportive (Baker et al., 2014; Hoebel, Richter, & Lampert, 2013; Lauridsen, Dal, & Folker, 2018) could support the men who are learning to navigate the system. Whether the men in this study had low health literacy remains unsubstantiated. However, the findings indicate that some of the men had difficulties in understanding information and instructions given by health professionals. Research on health literacy highlights that health literacy affects individuals entering and navigating the healthcare system as well as interacting with health professionals (Sørensen et al., 2012). The men in this study perceived all services as a unified system and struggled to find out which

parts of the system they should turn to for help and support, which may suggest that health literacy, to some extent, may influence how the men benefit from healthcare services.

Supporting Men's Peer Support

A recent study shows that peer support for vulnerable people at risk of type 2 diabetes was suitable for strengthening health literacy among socially marginalised Danish men (Ahlmark & Dindker, 2017). Peer support refers to emotional, social, and practical assistance provided by nonprofessional's (Ahlmark, Pernille, Jensen, & Dindler, 2016; Sokol & Fisher, 2016). Ahlmark and Dindker (2017) illustrate how healthcare activities in relation with peer-support activities were an opportunity for some men to participate in a social network, which they seemed to appreciate. In this study, the socially marginalised men visited the bench sites because doing so entailed a feeling of belonging, which the men valued because several had sparse networks.

Since AOD use was part of the social norms at the bench sites, this was an activity the peers did together. Consequently, the social networks at the bench sites may act as a determinant in relation to AOD use. A recent study supports how social environment and particular places may be important determinants (Thorpe et al., 2015). Other studies confirm how social networks may act supportively (Doblyte & Jiménez-Mejías, 2016; Patel, Frausto, Staunton, Souffront, & Derose, 2013) and have the power to influence and promote positive health behaviour (Hindhede & Aagaard-Hansen, 2017). This study indicates how the social networks at the bench sites acted as both an influencing factor and a concurrent support system. However, health professionals should explore this further through constructive relationships. Initiatives aimed at supporting the men's health may benefit from including elements from peer support since the men already take advantage of such an approach. This, however, is unsubstantiated and needs further exploration.

Gender and Masculinity

This study displayed delayed action or abandonment in health-related help-seeking behaviour because gender roles and masculinity seemed to influence some of the men's decisions regarding help-seeking. This is supported by a review written by Galdas et al. (2005) that found traditional masculine behaviour can serve as an explanation for delayed help-seeking behaviour. This corresponds, to some extent, with this study's findings, where some of the men at the bench sites leaned on masculine gender-specific norms by attempting to appear independent, self-reliant, strong, robust, and tough while also showing an interest in talking to and supporting peers who were facing health challenges.

A growing body of research argues that gender is not a stand-alone variable that can serve as an explanation of men's access and engagement in healthcare (Galdas et al., 2015). However, several of the men in this study expressed and showed that they, as men, were shaped by the culture from their working lives and from their upbringings, which encouraged masculine characteristics. This is in line with a study on depression among men, where men were aligned with certain qualities such as displays of strength, stoicism, and instrumentality as well as the capacity to produce material wealth (Oliffe et al., 2013). In this study, these masculine characteristics were often shown in the men's behaviour at the bench sites. Nevertheless, several of the men also engaged in supportive relationships at the bench sites. This indicates that relying solely on gender stereotyping as an explanation for men's health perceptions seems incomplete.

Several studies show that if targeted interventions are made for specific civic groups, it is possible to reach the citizens who have the greatest needs (Olsø, Almvik, & Norvoll, 2014; Skatvedt & Andvig, 2014; Weinehall et al., 2001). This may be true if such specific citizen groups are socially marginalised men. This is so far unsubstantiated. However, this study's findings are interesting

because they explore the men's contextualised understandings of health and health-related help-seeking, providing evidence for future explorations in this area.

COMPREHENSIVE COMPETENCIES

Flexibility and Deviation from Standard Practice

The men's perceptions of health were related to specific emotional states such as subjective feelings of well-being and balance in life as well as their estimations of their own competencies and abilities to participate and manage everyday life. The men's perceptions of health corresponded to a broad understanding of health, indicating a more holistic view rather than just the absence of illness and disease, which emerges from the biomedical understanding of health (Povlsen, 2013a; Sundhedsstyrelsen, 2005; Thybo, 2004; Wackerhausen, 1994). Since the men's health was influenced by individual actions and their social relations and interactions, health may be grasped as a kind of resource that makes the men able to participate in everyday life and society and engage in the activities they find meaningful (e.g., sitting on the bench while drinking alcohol or smoking cigarettes or a joint). This consequently indicates that health was not a goal but rather an agent or means to a meaningful life (Otto, 1998).

The findings in this study reveal how the men's previous experiences produced suspicions towards health professionals because the professionals tended to focus on risky health behaviours rather than the men's actual health problems. Since several of the men had bad experiences in the past, forming constructive relationships with the health professionals might be a challenge, as it would require a persistent and iterative approach. Consequently, forming a constructive relationship requires comprehensive competencies from the professional, who cannot back out when users show reluctance. Because of the men's broad understanding of health, professionals will have to learn,

understand, and respect the underlying rationale behind the men's understanding. It is likely that from an outsider's perspective, the men's current lifestyles with AOD use may seem remarkable and perhaps outside what society defines as normal behaviour (Brüne et al., 2018; Dybbroe & Kappel, 2012; Kappel, 2015; Ludvigsen & Brünés, 2013), even though it is part of everyday life for the men and thus is a matter of being able to function socially in the given context. This might suggest that professionals apply an approach based on the principles of harm minimisation. Harm minimisation is a preventive approach aimed at reducing AOD-related harm rather than promoting abstinence (Diderichsen et al., 2012; Järvinen & Andersen, 2006), an approach that has gained a strong foothold within the treatment system in Denmark (Ege, 2010).

Other research stresses how professionals need to use their authority and care even when users apparently reject help (Skatvedt & Andvig, 2014). However, as this study suggests, the men disapprove of professionals who seem to govern their lives, especially by telling them to stop their AOD use. Other studies stress how the use of weak paternalism may be allowed if it does not conflict with the goals and interests of socially marginalised people (Lauridsen et al., 2018). Vallgårda (2008) argues that the healthcare system already performs paternalism by using outreach approaches, indicating that these men are already exposed to a paternalistic approach. One can say that the men of this study accept weak paternalism that, as Lauridsen et al. (2018) argues, does not conflict with their interests, thus respecting their integrity.

According to Curtis and Bech (2012), interdisciplinary work requires special competencies in relation to interdisciplinary work, including competencies to create networks when working across policy sectors. However, their study stresses that the most successful cooperation is facilitated by personal knowledge (Curtis & Bech, 2012). This is similar to this study's findings. Nevertheless, this study found the strategy of using personal knowledge to be insufficient for working across policy sectors because personal relationships

did not always exist between the employees in different departments. This study's findings contributed to direct attention towards the complexity of cooperation across departments, especially in relation to the socially marginalised men with intertwined healthcare and social care needs.

Relational Competencies and an Outreach Approach

Based on this study's findings, it is relevant to discuss which competencies may be important for a professional to possess to be able to develop a relationship with the men and to cooperate across policy sectors to support the men's health needs. Brøbecher and Delmar (2007) use the concept of "relational competences," which involves special skills and concrete performances, ability to sense, reflection, use of previous experience, and professional immersion, as well as identity potentials, which are basic attitudes related to the practical aspects of care. Other studies emphasise how personal characteristics and attitudes are essential as well, especially a strong engagement and tenacity so as to form constructive relationships (Sterling et al., 2011). This study's findings reveal how the men requested less focus on changing their behaviours and more focus on remedying current health problems based on knowledge of their health challenges and life situations. The men wanted to be respected and feel an engagement and a professional interest in their lives; they also wanted the professional to be open, honest, and caring while showing respect and recognition to gain trust. In order to support socially marginalised men's health needs, different competencies are needed such as relational competencies and professional competencies.

Some of the men in this study received health and social support from the municipal Outreach Team. This support seemed to be a feasible approach because of frequent visits by the Outreach Team to the bench sites or similar places. Other studies have found that personal touch, such as a friendlier approach from outreach professionals, impacts decisions to attend health checks (Sinclair & Alexander, 2012). Additional research has found that the

prompt resolution of health and social issues by outreach teams is highly valued (Brüne et al., 2018; Diderichsen et al., 2015; Smith, Braunack-Mayer, Wittert, & Warin, 2008; Sundhedsstyrelsen & COWI, 2015). Still, this study emphasises how the use of the Outreach Team depended upon the team literally seeking out the men at various hangout places in town. As such, it seems that the men's health-related help-seeking was based on the initiative of and the relationship with the Outreach Team, which may indicate that outreach teams, through their methods, may help to bridge the gap between healthcare and social care.

5.2 REFLECTIONS ON RESEARCH PROCESS, DESIGN, AND METHODS

In the following methodological framework, the research process, design, and methods will be reflected on.

PRAGMATISM

This research started with my curiosity, which is in line with abduction, known from pragmatism (Eriksson & Lindström, 1997; Råholm, 2010), which entails starting from surprising, curious, or somehow anomalous phenomena. Abduction portrays the potential and the possibilities in theory development and is closely related to the ontological question: What do we mean by health? (Råholm, 2010). This is a central question in this research, which engages with the ongoing public health dialogue on how the individual constructs health (Glasdam, 2009). In deduction and induction, particular conclusion forms a general premise and general conclusion from a set of particular statements happen, whereas in abduction, searching for an idea itself is central (Mirza, Akhtar-Danesh, Noesgaard, Martin, & Staples, 2014; Råholm, 2010). The pragmatic perspective seemed a relevant choice for this research because it presents an opportunity to search for a new depiction of a new reality, and the abductive interpretation of new patterns offers deeper levels of knowledge

because it allows for an ongoing shift between theory and empirics in order to find explanatory hypotheses. However, the pragmatic perspective has not been without challenges. I experienced being a prisoner of conceptual deduction when I began the analysis using NVivo. I started by exclusively forming research categories based on the theoretical concepts; health, social marginalisation, and inequality in health. I elicited trustworthy conclusions but not new knowledge. Still, I found that by having a thorough theoretical basis and good knowledge of the field of research, I was capable of thinking in new ways and exploring the indefinite of the phenomena. The top challenge as a researcher was to transform the knowledge to external form such as by expressing ideas in a certain way so that these ideas are understandable and accessible for other people.

ETHNOGRAPHIC STUDY

Ethnography was chosen as a methodology to enable an exploration and description of how to support socially marginalised men's health needs based on the men's and municipal employees' perceptions and experiences. The importance of social and contextual influences in relation to health perceptions proved to be significant, emphasising the relevance of using ethnography to explore and describe the situation in an in-depth way. The participant observation and interviews provided insight into how health is socially constructed based on the participants' perspectives in everyday life and in their professional lives. The ethnographic approach enabled a research process that unfolded complex issues (Morse, 2005; Savage, 2006) and was appropriate for topics about which little is known (Lambert, 1990). Therefore, the ethnographic approach seemed well chosen because it leaves space for fluidity and flexibility (O'Reilly, 2012), which allows openness to all the participants' health perceptions and understandings of health. Some of the limitations of using the ethnographic methods are elaborated on in this section, under Methods.

Sampling

The participants in substudy 1 were sampled through purposeful and snowball sampling. The material represents views from men from two bench settings. It can be argued that eliciting the perspectives from other bench sites in the municipality or by getting in touch with more men who did not frequent the bench sites may have provided more robust material. I planned to include more men from outside the bench sites, which could lead to more diversity in the sample (Hale, Grogan, & Willott, 2010); the participants would be diverse in terms of location. However, findings showed that regardless of men's socialising in everyday life, all socially marginalised men suffered from a variety of health challenges and had varying experiences with healthcare services regardless of their place of socialisation. Using snowball sampling in substudy 1 could be a limitation. One reason could be that it was not clear why some of the men even offered to join the research. There could be various reasons why men wanted to be involved in this research; for example, some of this study's men perceived me as a form of counsellor, and they wanted someone to talk to. Another reason could be because the men who volunteered were primarily men who had strong and significant attitudes or interest in what I was investigating or, for example, only wanted to talk to me in order to criticize the entire public sector. Such uncertainties or similar when using snowball sampling is well known by other researchers (Morse, 1991).

The participants in substudy 2 were sampled through purposeful sampling through the support monitor group. This was an advantage because I obtained equal representations from two departments that had offers that might benefit the socially marginalised men. A limitation was that the members of the support monitor group naturally had an overview in their "own" departments, which limited the views and knowledge I acquired on other departments in the municipality and their contact with socially marginalised men. It can therefore be argued that there is a risk that I did not obtain the most relevant employees' insight. I had planned to get equal representations from employee and

manager levels just to achieve a broad and nuanced picture. There are differences in attitudes and understandings that can probably be attributed to the difference in levels of employment. It is also a limitation that not all employees had been in contact with socially marginalised men. Therefore, some of the participants had only limited knowledge about offers they thought could benefit the men. However, they contributed with reflections on what challenges the municipality as an organization had in relation to helping marginalised citizens, which was in line with the overall aim of this research.

Methods

Interviews

Interviews were used in both substudies, and reflections related to that will be discussed for substudies 1 and 2, respectively.

In substudy 1, interviews, together with participant observations, were chosen to allow an exploration of the implicit and explicit health perceptions among the men (Wackerhausen, 1994). I prepared for the interviews by reflecting on my preunderstandings; still I found that the formal interview guide unintentionally used words and understandings from my health-professional world, thereby exploring a narrow understanding of health. This caused some of the men to be annoyed when they were asked questions that they seemingly felt were irrelevant. This led to further reflections on the key topics of the interviews, which I refined according to each individual man's jargon. This, however, resulted in wider interpretations of the meanings behind the answers, which have made the analysis complex as far as finding similarities in the patterns and themes in the material, especially because the men used different emotional states to describe health.

In the interviews, I was interested and curious, and I sometimes went far beyond the key topics, drawing forth my own experiences and telling embarrassing stories about myself. I did so with the aim to build up a

constructive relationship with the participating men. I tried making the participants feel confident in me and comfortable with me and my questions by creating a friendly and cosy atmosphere. I seemed to succeed, because several of the men told me that our talk had been nice and asked if I would come and talk to them again. Still, I repeatedly reminded the participants of the reason we met by waving the piece of paper on which the key topic questions were written. I did this as a reminder of the reason we met, in order to not mislead them into believing it was a friendship. Still, I experienced that some of the men felt connected to me, which meant that I had to pay close attention to ending the relationship in a way that did not cause too much distress (Baarts, 2015; Madden, 2010). I had advised the men that my time with them at the bench sites would end. The day I visited the bench for the last time, I invited them to breakfast. In this way, I returned the "gift" (Mauss, 2002) they had shown me in terms of access to their everyday lives, with the "gift" breakfast as an expression of my gratitude.

Some conversations with the men took place at the bench sites among groups of men sometimes contributing with a wide range of experiences, views, and/or responses that would comply with the overall aim of this study, thus providing direct access to action and not just stories of action, which differs from the classic forms of individual interviews (Halkier, 2016). This made me reflect on using focus group interviews instead of single interviews. However, solely using focus group interviews might entail a risk that the social control in a focus group of socially marginalised men would prevent all differences in experiences and perspectives from emerging because of a sometimes harsh tone between the men, which might be enhanced by their AOD usage. Such episodes occurred during the discussions I attended at the bench sites. Some issues would be considered uninteresting or irrelevant, which entailed that some of the men deviated from telling their very personal stories, and others departed from the bench. By contrast, in the individual interviews, the men

were being very open. Due to this, focus group interviews may have been problematic in terms of this study's overall aim.

In substudy 2, single interviews were planned. However, one interview with two participants together added an interesting dimension to the interview, where the participants complemented each other's narratives. This made me reflect on the relevance of using focus group interviews because it may contribute a range of experiences, views, and/or responses. Participants may inspire each other so that there are several nuances and perspectives on a topic (O'Reilly, 2012). Still, I did find that the single interviews provided knowledge by allowing the participants the opportunity to make nuanced descriptions based on their own experiences (O'Reilly, 2012). This has provided a deep insight into various participants' attitudes, opinions, and values in relation to exploring the men's health perceptions and in relation to supporting socially marginalised men's health, complying with the overall aim of this study.

Overall, using single interviews certainly widened my understanding of the participants by offering them a lot of speaking time and giving me, as a researcher, the opportunity to ask about each individual's understandings, perceptions, and experiences (O'Reilly, 2012), which is in contrast to a focus group interview (Halkier, 2016). The individual interviews conveyed the social construction of perceptions and attitudes through the participants' interactions with me. Such social constructs are closely linked to what characterises the pragmatic perspective (Brinkmann, 2006; Morgan, 2014; O'Reilly, 2012).

Participant observations

Using participant observations was not without limitations: Firstly, a large amount of ethnographic material was produced, some of which was not centred in relation to the overall aim of this study but was more related to negotiating access to the field. Secondly, field notes are one of the most

important tools used as a researcher. But because I couldn't write field notes while on the bench, I had to rely on my memory, which at times made it difficult to fully remember the small details of the specific context. However, several times I stored different observations that other researchers refer to as "headnotes" (Baarts, 2015). Such headnotes were stored in my experience and memory, allowing such observations to appear later, proving to be of significance. However, this is a major limitation, as there is no guarantee that such headnotes could be reactivated.

I also experienced challenges in the relationship between professionalism and friendship (Baarts, 2015). This was closely related to the sample size. The participating men felt confident in me and were so comfortable with me and my questions that they asked if they could talk to me again. Because I seemed to contribute with something positive to their lives, I had difficulty retaining the research role because I felt I could contribute a relief here and now. Because the empirical reality was so complex, it was a big limitation that I found it hard to know when I should leave the field. I discussed this issue thoroughly with my supervisors, and even though there was not a given time for when I, as a researcher, could or should leave the field, I chose to leave when some kind of saturation appeared, in that the topic was fully investigated and no new interpretations were generated from additional participation.

In sum, one of the strengths of participatory observations was that the social action is the source of the ethnographic material by producing knowledge of the complexities of meaning formation and social practices (O'Reilly, 2012), which is in line with the pragmatic assumption that knowledge is socially constructed (Brinkmann, 2006; Morgan, 2014; O'Reilly, 2012).

Analysis of the Material

Epistemologically, the interviews and observations drew on different conditions, such as the emic and etic perspectives. While the excerpts from

the interviews were mainly based on emic data from the men's perspectives, the participant observations were mainly based on etic data (i.e., my interpretation of what happened) (Madden, 2010). Nevertheless, I chose to analyse the interviews and participant observations in substudy 1 together. This choice was inspired by Agar (1996), who claimed that observations may correct the accounts from the interviews, as interviews only give an insight into the parts the men want to share with me. This, however, contrasts a pragmatic approach, because true pragmatic knowledge is knowledge that, through action, is useful in practice and benefits people. The central notion of pragmatism focuses on the nature of truth, and, put simple, truth is found in "what works," and that truth is relative to the current situation (Brinkmann, 2006). However, interviews and observations guide each other, opening my eyes to some things I otherwise would not have noticed. Issues from one empirical context allowed an exploration in another empirical context (Hastrup et al., 2017), or, as O'Reilly (2012) argues, something may be omitted to protect others or because it seems obvious or uninteresting (O'Reilly, 2012).

I have not assessed one form of material over the other; the participant observations and interviews have been equally represented. One can critically argue that giving rich descriptions depends on my ability to provide comprehensive descriptions of the social world of the men. Thus, I have viewed the different forms of talk, as described by Atkinson (2015) as embedded in the social worlds. This has enabled me to incorporate different types of material such as field notes and interview transcripts, which may compose a more three-dimensional perspective on the phenomenon under research (Miles et al., 2014).

The analysis was linked to the abductive reasoning, known from pragmatism (Atkinson, 2015, 2017), due to extensive familiarity with existing theories at the outset and throughout every research step (Timmermans & Tavory, 2012). However, the disadvantage of working abductively is that there are many paths to follow, and there is a risk that I, as a researcher, chose the path that

was most familiar to me. That way, I may have reproduced my own point of view in terms of what the problem is. Abduction provides the opportunity to work creatively and innovatively with problem-solving (Brinkmann, 2013), but that does not in itself mean that is what happens. In order to not reproduce what I already knew in advance, an abductive approach that was guided by a theoretical framework such as gender, health literacy might have helped me deal with the diversity that abduction provides. However, it is also important to remember that abductive reasoning only claims that an explanation is better than its immediate competitors'. It does not claim that it is better than any other possible alternative (Brinkmann, 2013). Thus, leaning on the ideas of Sandelowski (1993) who suggests that theory may be useful when it does not distort the meaning of the material. Based thereupon, I chose theoretical openness because I wanted to conduct an analysis without determining in advance what I thought this was about. Thereby, theory in this research has worked provisionally and not prescriptive, it has been flexible rather than definitive and controlling. I wanted to give the men a voice – a voice that, until now, only appeared in the anecdotal evidence. However, this was not without challenges which will be elaborated further in the next section, Trustworthiness, under Confirmability.

TRUSTWORTHINESS

Different methodological strategies have been used to ensure the trustworthiness of the findings. The strategies are discussed within the scientific criteria of confirmability, dependability, credibility, transferability, and utilisation (Miles et al., 2014). The concept of trustworthiness was used parallel to the conventional quantitative assessment criteria of validity and reliability (Nowell, Norris, White, & Moules, 2017; Shento, 2004).

Confirmability concerns addressing neutrality (Miles et al., 2014). In substudies 1 and 2, I have used myself as a tool throughout the research process. Hence, this study has not been conducted without any personal

involvement. Like described by Wolcott (2005), any study among people involves a concern for the humans whose lives touch us as researchers (Wolcott, 2005). This means that it is impossible to feel no interest or concern for the participants. I was touched by the participating men's stories, especially the stories of horrible experiences such as abuse and rape, which radically changed their lives, or stories about taking care of one's best friend by protecting him. Such stories entailed interest and concern, which are feelings that I, as Wolcott (2005) stresses, had to recognise and appreciate to transform them into a source of energy for conducting my study. I experienced that these feelings influenced my analysis of the data because I presented the men as struggling more than they really were. Through discussions with my supervisors, I became aware of this inconvenience. I experienced that I struggled to set aside my professional background as a nurse as well as my theoretical background, for which reasons my choice of a theoretical open abductive approach in the analysis was challenged. I was obviously more coloured by my preunderstanding than I was aware of, even though before the study started, I took part in an interview with a colleague about my preunderstanding and reflections on how I would relate to my nursing background in the process (Madden, 2010). My supervisors have continually throughout the study challenged my preunderstandings and presumptions. Thus, my preunderstandings have led to sometimes inconsistent and conflicting findings because my professional view on health and healthcare seemed to originate from a biomedical understanding. This led me to focus on the men's risky health behaviours rather than exploring how they perceived health and the complexities of meaning formation related to health and social practices as health-seeking behaviours.

Dependability concerns consistency throughout the research process (Miles et al., 2014). Through structured and transparent reporting of the study process, I have aimed to respond to the fact that when reality is a social construction and constantly changing, the dependability originates from

capturing these changing conditions by describing the origin of every research step taken from the start of a research project to the development and reporting of the findings (Korstjens & Moser, 2018). I intended to let other readers relate to consistencies and inconsistencies of this study. However, by using reflexivity as a method (Madden, 2010) throughout the process, this study offers transparent and dependable findings.

Credibility concerns whether the findings of the study make sense to readers of this study as well as to the men and employees I have studied and that the research findings present plausible information drawn from the material (Miles et al., 2014). As one strategy to ensure credibility, triangulation (Miles et al., 2014) was performed. In particular, researcher triangulation (Miles et al., 2014) was used to reflect the findings. I discussed with my supervisors whether the participants' original views matched my interpretations. Furthermore, triangulation of material was conducted (Miles et al., 2014), such as with the participatory observations and interviews. I could have chosen to confirm the accuracy of the findings with the participants to convey further credibility to the study's conclusions (Miles et al., 2014). However, this would have been contrary to the pragmatic approach in this study, because knowledge is not given but must be invented together since our experiences are tied up and contextual and procedural (Brinkmann, 2006). This means that the pragmatic perspective leaves room for construction of multiple answers. By investing time at the bench sites and engaging with the participating men, I became familiar with the social contexts, increasing the possibility for building up trust so as to get rich material. However, one limitation was that full membership could not be achieved since I neither have the right gender nor was one of them socially. Another limitation was that by using a step-in-step-out method (Madden, 2010), I only took part in a small portion of their lives.

Transferability concerns providing readers with evidence that the study's findings could be applicable to other contexts, situations, times, and populations (Miles et al., 2014). This thesis's results represent a construction

between the participating men, the employees, and me. I have striven to provide descriptions involving the context or relation in which the material emerges. To ensure quality in the research project, my goal was to provide clarity in my description of the strategic selection. I have described which optional choices and endorsements lie behind the selection of participants and material, and I argue for my choices. The material is thereby based on a strategic and purposeful selection. Access to such information helps construct the scene that surrounds this research study, from the daily lives of participants to the way that their underlying assumptions may affect their responses, allowing readers to access the potential transferability to their own settings.

Utilisation concerns who benefits or who may be harmed by the research (Miles et al., 2014). In this research, ethical concerns and dilemmas arose when I attended my first PhD course in qualitative research methods. I was asked by the teaching professor how I could justify doing a study on socially marginalised men who never asked to become study objects; he said this study solely emerged from my own professional curiosity. The answer lies between professional and ethical reflections. This study was motivated by consideration of inequality in health and by a desire to benefit men's quality of life, because socially marginalised men have poor health and low life expectancy (Baker et al., 2014), and the knowledge gap on how to support socially marginalised men's health needs is significant. Conversely, one can raise the objection that this study is offensive to the men's autonomy – that is, their right to self-determination and privacy (Liamputtong, 2007). Moreover, it entails labelling the men as socially marginalised, which may contribute negatively to their quality of life. However, by this research, I express and articulate their voices, for which reason I chose a theoretical openness in the analysis. Accordingly, other researchers argue that it is not immoral to include vulnerable people in research if it is done ethically (Beauchamp, Jennings, Kinney, & Levine, 2002; Keogh & Daly, 2009). Others argue that the benefits

of undertaking research among vulnerable people need to be measured against the risks of being involved in research (Flaskerud & Winslow, 1998). In this research, the participating men were able to talk about matters that they might not otherwise have had a chance to talk about in everyday life. Several of this study's participating men expressed how they, in our conversations, felt that at last someone listened to their stories and problematic everyday lives. Several asked for a rain check and the possibility to talk to me again. Others commented on how they hoped I found out something that would help "someone like them." A similar situation is reported in research by Grinyer (2004), in which her participants found the research process therapeutic (Grinyer, 2004). Still, as argued by Koivisto, Janhonen, Latvala, and Väisänen (2001), all participants included should receive special consideration; thus, the men's situations are always individual (Koivisto, Janhonen, Latvala, & Väisänen, 2001). Even so, all the men expressed their willingness to be involved in this research and to make their voices heard and were grateful that somebody was interested in their opinions and feelings. Furthermore, the men also showed how they had an interest in inviting me into their everyday lives. An example was that by offering to repair my bike, the men offered me a gift. According to Mauss (2002), gifts create social ties, and he argues that human beings are basically social individuals wishing to enter and create social networks. By offering me the gift pedal repair, a social bond arose between us, and our relationship was confirmed. Studies among socially marginalised men seem important because they produce new insights that might benefit professionals who, in their daily jobs, need to get in touch with men with similar characteristics, because these men have not often had opportunities to state their opinions (Larsen, 2005; Wiebel, 1990).

6 CONCLUSION

The overall aim of this PhD research was to explore socially marginalised men's experiences and perceptions of health in the context of their everyday lives. The aim was also to explore municipal employees' experiences and perceptions of how to support socially marginalised men's healthcare needs and contribute with perspectives and clarification of possible challenges. Based on the analysis, findings, and discussion, I conclude the following:

Socially marginalised men perceive health as related to the ability to participate in daily life and admission to social networks. Various personal, physical, and mental health challenges influence their ability and desire to participate. Thus, health is grasped as a kind of resource, indicating that health is not a goal but rather an agent or means to a meaningful life.

Socially marginalised men have several complex and interacting social- and health-related conditions, which seem to affect their health-related help-seeking behaviour. They seem not to benefit from municipal healthcare services; however, they occasionally meet the Outreach Team, who succeeded in supporting their healthcare needs in such a way that the men experienced being treated respectfully by being talked *to*, not talked *at*, and were accepted for their life choices, including their AOD use.

Professionals need to focus on relational competencies to support the health needs of the men, including special skills and concrete performances, ability to sense, reflection, use of previous experience, and professional immersion, involving a harm-minimisation approach. It is crucial that professionals have comprehensive competencies to support the men's intertwined health and social needs and work actively to encourage peer support. By focusing on forming constructive relationships with the socially marginalised men, professionals will learn about their everyday life challenges and social

challenges, which influence the men's health. All of this is important to find out how to support the men's healthcare needs and develop the municipal healthcare services.

Knowledge of the men seems to exist across policy sectors and professional boundaries, for which reason interdisciplinary cooperation is important to identify and cooperate with the men. Findings suggest appropriate individual-tailored solutions and involving employees from other municipal departments with other competencies if necessary. Participants promoted the demand for special competencies to support the men's complex and intertwined challenges. However, this research shows how knowledge about other policy sectors' departments' work routines and information seems difficult to access unless previous cooperation across departments has been performed.

Integration between healthcare and social services seems to be acknowledged strategically and politically by the municipality's expressed intent to address complex and intertwined health and social challenges. However, on the operative level of the organization, the participants experienced a lack of acknowledgement due to lack of interdisciplinarity across policy sector boundaries.

7 PERSPECTIVES

This research explored socially marginalised men's health perceptions and municipal employees' experiences and perceptions of how to support them, highlighting several issues of importance. It is important to acknowledge that this study's findings are only the first step. The next step should be research on how to implement the insights generated by this study in the municipality, preferably through user involvement.

This research is an important contribution to other studies on marginalised citizens. This study's socially marginalised men have many of the same problems, such as risky health behaviours, as other socially marginalised citizens shown in other studies. The men handle their health in a different way than the healthcare system recommends. They use alcohol and joints, which is meaningful or rational from their perspective and internal logic. However, this research also shows that these men have resources that could be activated through support from professionals or peers, and it seems that outreach teams, through their methods, may help to bridge the gap between healthcare and social care. I suggest that before increased efforts with more outreach services are introduced, a study similar to this one should be carried out on outreach services in relation to increasing socially marginalised citizens' use of municipal healthcare.

This study also draws attention to the fact that further research on socially marginalised men's health literacy is needed. Much is unknown, including how it is possible to support health literacy accordingly with the complexity in these men's everyday lives. This research indicates that the undeveloped potential of peer support is important to the men. Consequently, further research is needed on that topic to provide a more nuanced picture and explore its potential.

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9 APPENDICES

A: Excerpts from literature searches

B: Bench area A & B

C: Key Topic Interview Guide-The Men

D: Key Topic Interview Guide-The Municipal Employee

E: Mail: Ethical Approval Scientific Ethical Committee

F: Mail: Ethical Approval Data Protection Agency

G: Information Material-The Men

H: Information Material-The Municipal Employees

I: Consent Formula–The men

J: Consent Formula–The Municipal Employees

A: Excerpts from literature searches

Literature search Aim A – via EBSCO Portal (SocIndex, PsycInfo, CINAHL Complete)

Søge-id#	Søgeord	Søgeindstillinger	Seneste kørt via
S62	S60 AND S61	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S61	middle age*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S60	S53 AND S59	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S59	S54 OR S55 OR S56 OR S57 OR S58	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S58	municipal*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S57	(MH "Community Medicine")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service

S56	(primary or communit*)	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S55	(MH "Community Health Centers")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S54	(MH "Primary Health Care")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S53	S46 AND S49 AND S52	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S52	S50 OR S51	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S51	Health* N3 (perception* or attitude*)	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S50	(MH "Attitude to Illness+") OR (MH "Attitude to Health+")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service

S49	S47 OR S48	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S48	health N3 (behaviour* or behavior* or pattern*)	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S47	(MH "Health Behavior+") OR (MH "Help Seeking Behavior")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S46	S44 AND S45	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S45	men* or male*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S44	S40 NOT S43	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S43	S41 NOT S42	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service

S42	S35 OR S36 OR S37 OR S38 OR S39	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S41	(MH "Mental Disorders")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S40	S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S39	alcoholism	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S38	(drug or alcohol) N2 (abuse* or addict* or misuse*)	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S37	(MH "Substance Abusers")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S36	(MH "Substance Abusers")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO

			Discovery Service
S35	(MH "Substance Abuse") OR (MH "Substance Abusers")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S34	low income* or poverty	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S33	unskilled*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S32	unemploy*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S31	vulnerab*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S30	(MH "Vulnerability")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S29	deprived life*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO

			Discovery Service
S28	social* N3 (expos* or exclu* or vulnera* or marginali*)	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S27	socio-economic* or socio economic*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S26	socioeconomic*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S25	(MH "Socioeconomic Factors+")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S24	S22 AND S23	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S23	middle age*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S22	S20 AND S21	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service

S21	men* or male*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S20	S16 NOT S19	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S19	S17 NOT S18	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S18	S11 OR S12 OR S13 OR S14 OR S15	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S17	(MH "Mental Disorders")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S16	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S15	alcoholism	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO

			Discovery Service
S14	(drug or alcohol) N2 (abuse* or addict* or misuse*)	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S13	(MH "Substance Abusers")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S12	(MH "Substance Abusers")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S11	(MH "Substance Abuse") OR (MH "Substance Abusers")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S10	low income* or poverty	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S9	unskilled*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S8	unemploy*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO

			Discovery Service
S7	vulnerab*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S6	(MH "Vulnerability")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S5	deprived life*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S4	social* N3 (expos* or exclu* or vulnera* or marginali*)	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S3	socio-economic* or socio economic*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service
S2	socioeconomic*	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service

S1	(MH "Socioeconomic Factors+")	Søgetilstande - Boolesk/frase	Grænseflade - EBSCO Discovery Service

Literature search Aim B – SveMed

1	men	2080
2	masculinity	45
3	gender	492
4	middle-aged	18227
5	socio-economic	21
6	hard to reach	1
7	hidden	109
8	invisible	65
9	#1 AND #4	403
10	#7 AND #9	0
11	#8 AND #9	0
12	#6 AND #9	0
13	#5 AND #9	0
14	#3 AND #9	8
15	healthcare utilization	398
16	service utilization	256
17	help seeking	30
18	health seeking	81
19	health attenders	46
20	access to care	170
21	#15 AND #17 AND #19	0

22	#15 AND #16	114
23	#9 AND #15	0
24	#9 AND #16	1
25	#9 AND #17	1
26	#9 AND #18	1
27	#9 AND #19	0
28	#9 AND #20	1
29	#2 AND #15	0
30	#2 AND #16	0
31	#2 AND #17	0
32	#2 AND #18	0
33	#2 AND #19	0
34	#2 AND #20	0

Literature search Aim C – PubMed

Search	Add to builder	Query	Items found
#63	Add	Search **((((((((((((((interdisciplinar*[Title/Abstract]) OR Multidisciplinar*[Title/Abstract]) OR interdisciplinar*[Title/Abstract]) OR Multidisciplinary Care Team*[Title/Abstract]) OR "Community Health Nursing"[Mesh]) OR municipal*[Title/Abstract]) OR "Community Medicine"[Mesh]) OR ((primary[Title/Abstract] OR communit*[Title/Abstract]))) OR "Community Health Services"[Mesh]) OR "Primary Health Care"[Mesh])) AND (((((((outreach[Title/Abstract]) OR harm reduct*[Title/Abstract]) OR "Early Intervention (Education)"[Mesh]) OR "Preventive Health Services"[Mesh]) OR "Harm Reduction"[Mesh]) OR (("Health Education"[Mesh]) OR "Health Promotion"[Mesh])) OR ((early intervent*[Title/Abstract] OR early detect*[Title/Abstract]))) OR ((health promot*[Title/Abstract] OR health educat*[Title/Abstract])))) AND ((((("Men's Health"[Mesh]) OR "Male"[Mesh]) OR "Masculinity"[Mesh]) OR ((men[Title/Abstract] OR male[Title/Abstract] OR masculin*[Title/Abstract] OR mens[Title/Abstract])))) AND (("Middle Aged"[Mesh]) OR middle age*[Title/Abstract])) AND (((((("Socioeconomic Factors"[Mesh]) OR Socioeconomic*[Title/Abstract]) OR socio econom*[Title/Abstract]) OR "hard to reach "[Title/Abstract]) OR "Social Determinants of Health"[Mesh])**	4086

Search	Add to builder	Query	Items found
#62	Add	Search **(((((((outreach[Title/Abstract]) OR harm reduct*[Title/Abstract]) OR "Early Intervention (Education)"[Mesh]) OR "Preventive Health Services"[Mesh]) OR "Harm Reduction"[Mesh]) OR (("Health Education"[Mesh]) OR "Health Promotion"[Mesh])) OR ((early intervent*[Title/Abstract] OR early detect*[Title/Abstract]))) OR ((health promot*[Title/Abstract] OR health educat*[Title/Abstract]))**	644247
#61	Add	Search **(early intervent*[Title/Abstract] OR early detect*[Title/Abstract])**	67522
#60	Add	Search **(healt promot*[Title/Abstract] OR health educat*[Title/Abstract])**	30799
#59	Add	Search **(((((((("Men's Health"[Mesh]) OR "Male"[Mesh]) OR "Masculinity"[Mesh]) OR ((men[Title/Abstract] OR male[Title/Abstract] OR masculin*[Title/Abstract] OR mens[Title/Abstract]))))) AND ((((((((((("Health Education"[Mesh]) OR "Health Promotion"[Mesh])) OR "Harm Reduction"[Mesh]) OR "Preventive Health Services"[Mesh]) OR "Early Intervention (Education)"[Mesh]) OR harm reduct*[Title/Abstract]) OR ((health[Title/Abstract]) AND (promot*[Title/Abstract] OR educat*[Title/Abstract]))) OR ((early[Title/Abstract]) AND (intervent*[Title/Abstract] OR detection*[Title/Abstract]))) OR outreach[Title/Abstract])) AND ((((((((((inter disciplinar*[Title/Abstract])**	7680

Search	Add to builder	Query	Items found
		OR Multidisciplinar*[Title/Abstract]) OR interdisciplinar*[Title/Abstract]) OR Multidisciplinary Care Team*[Title/Abstract]) OR "Community Health Nursing"[Mesh]) OR municipal*[Title/Abstract]) OR "Community Medicine"[Mesh]) OR ((primary[Title/Abstract] OR communit*[Title/Abstract])) OR "Community Health Services"[Mesh]) OR "Primary Health Care"[Mesh]))) AND (("Middle Aged"[Mesh]) OR middle age*[Title/Abstract])) AND (((((("Socioeconomic Factors"[Mesh]) OR Socioeconomic*[Title/Abstract]) OR socio econom*[Title/Abstract]) OR "hard to reach "[Title/Abstract]) OR "Social Determinants of Health"[Mesh])	
#58	Add	Search **((((("Socioeconomic Factors"[Mesh]) OR Socioeconomic*[Title/Abstract]) OR socio econom*[Title/Abstract]) OR "hard to reach "[Title/Abstract]) OR "Social Determinants of Health"[Mesh]**	457993
#57	Add	Search **"Social Determinants of Health"[Mesh]**	1405
#55	Add	Search **"hard to reach "[Title/Abstract]**	1491
#54	Add	Search **socio econom*[Title/Abstract]**	27123
#52	Add	Search **Socioeconomic*[Title/Abstract]**	83593

Search	Add to builder	Query	Items found
#51	Add	Search **"Socioeconomic Factors"[Mesh]**	405312
#49	Add	Search **(((((("Men's Health"[Mesh]) OR "Male"[Mesh]) OR "Masculinity"[Mesh]) OR ((men[Title/Abstract] OR male[Title/Abstract] OR masculin*[Title/Abstract] OR mens[Title/Abstract]))))) AND ((((((((((("Health Education"[Mesh]) OR "Health Promotion"[Mesh])) OR "Harm Reduction"[Mesh]) OR "Preventive Health Services"[Mesh]) OR "Early Intervention (Education)"[Mesh]) OR harm reduct*[Title/Abstract]) OR ((health[Title/Abstract]) AND (promot*[Title/Abstract] OR educat*[Title/Abstract]))) OR ((early[Title/Abstract]) AND (intervent*[Title/Abstract] OR detection*[Title/Abstract]))) OR outreach[Title/Abstract])) AND ((((((((((inter disciplinar*[Title/Abstract]) OR Multidisciplinar*[Title/Abstract]) OR interdisciplinar*[Title/Abstract]) OR Multidisciplinary Care Team*[Title/Abstract]) OR "Community Health Nursing"[Mesh]) OR municipal*[Title/Abstract]) OR "Community Medicine"[Mesh]) OR ((primary[Title/Abstract] OR communit*[Title/Abstract]))) OR "Community Health Services"[Mesh]) OR "Primary Health Care"[Mesh])))) AND (("Middle Aged"[Mesh]) OR middle age*[Title/Abstract])**	44114
#48	Add	Search **("Middle Aged"[Mesh]) OR middle age*[Title/Abstract]**	3916711

Search	Add to builder	Query	Items found
#47	Add	Search **middle age*[Title/Abstract]**	43469
#46	Add	Search **"Middle Aged"[Mesh]**	3901338
#44	Add	Search **(((((("Men's Health"[Mesh]) OR "Male"[Mesh]) OR "Masculinity"[Mesh]) OR ((men[Title/Abstract] OR male[Title/Abstract] OR masculin*[Title/Abstract] OR mens[Title/Abstract]))))) AND ((((((((((("Health Education"[Mesh]) OR "Health Promotion"[Mesh])) OR "Harm Reduction"[Mesh]) OR "Preventive Health Services"[Mesh]) OR "Early Intervention (Education)"[Mesh]) OR harm reduct*[Title/Abstract]) OR ((health[Title/Abstract]) AND (promot*[Title/Abstract] OR educat*[Title/Abstract]))) OR ((early[Title/Abstract]) AND (intervent*[Title/Abstract] OR detection*[Title/Abstract]))) OR outreach[Title/Abstract])) AND ((((((((((inter disciplinar*[Title/Abstract]) OR Multidisciplinar*[Title/Abstract]) OR interdisciplinar*[Title/Abstract]) OR Multidisciplinary Care Team*[Title/Abstract]) OR "Community Health Nursing"[Mesh]) OR municipal*[Title/Abstract]) OR "Community Medicine"[Mesh]) OR ((primary[Title/Abstract] OR communit*[Title/Abstract]))) OR "Community Health Services"[Mesh]) OR "Primary Health Care"[Mesh]))**	91587
#43	Add	Search **(((("Men's Health"[Mesh]) OR "Male"[Mesh]) OR "Masculinity"[Mesh])**	7949386

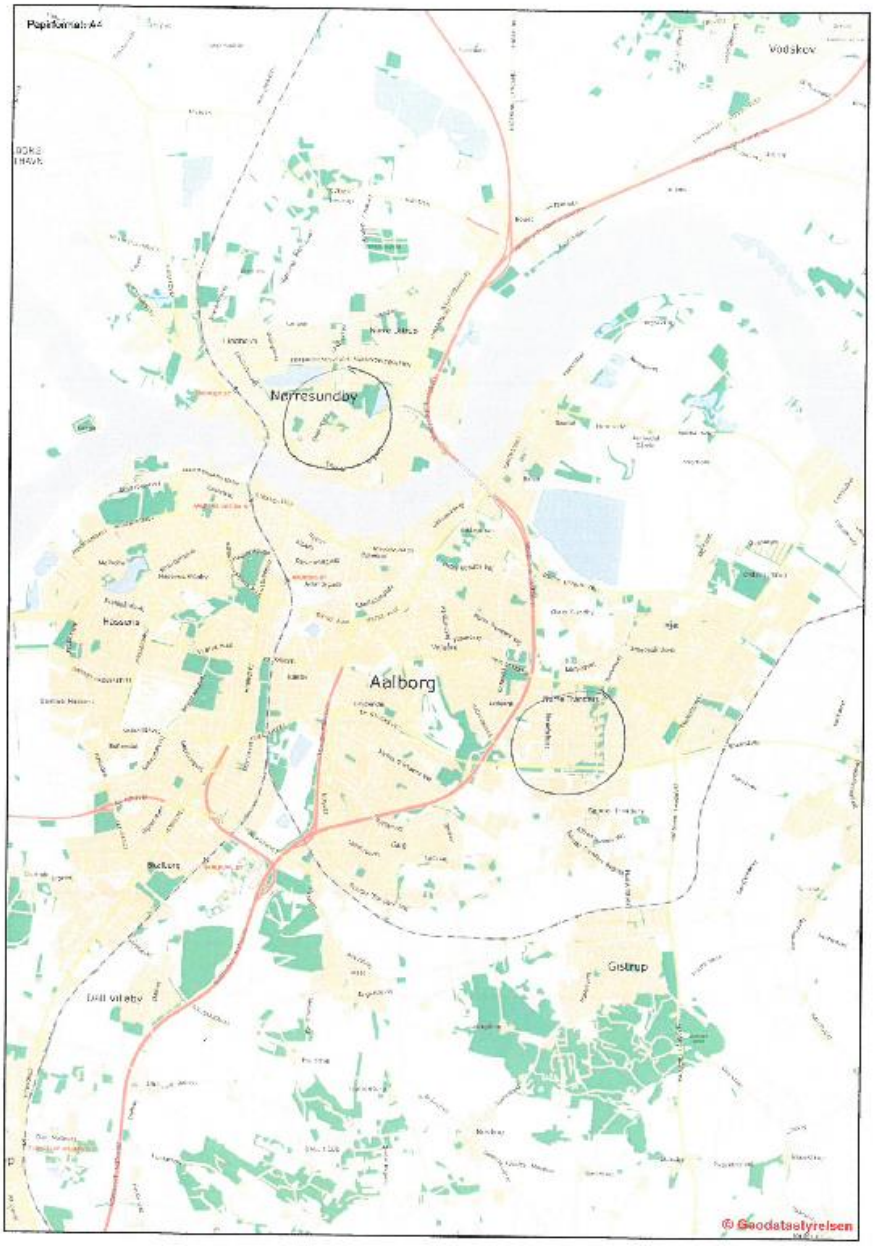
Search	Add to builder	Query	Items found
		OR ((men[Title/Abstract] OR male[Title/Abstract] OR masculin*[Title/Abstract] OR mens[Title/Abstract]))	
#42	Add	Search **(men[Title/Abstract] OR male[Title/Abstract] OR masculin*[Title/Abstract] OR mens[Title/Abstract])**	1142752
#41	Add	Search **"Masculinity"[Mesh]**	1002
#39	Add	Search **"Male"[Mesh]**	7756628
#37	Add	Search **"Men's Health"[Mesh]**	1587
#35	Add	Search **((((((((((("Health Education"[Mesh]) OR "Health Promotion"[Mesh])) OR "Harm Reduction"[Mesh]) OR "Preventive Health Services"[Mesh]) OR "Early Intervention (Education)"[Mesh]) OR harm reduct*[Title/Abstract]) OR ((health[Title/Abstract]) AND (promot*[Title/Abstract] OR educat*[Title/Abstract]))) OR ((early[Title/Abstract]) AND (intervent*[Title/Abstract] OR detection*[Title/Abstract]))) OR outreach[Title/Abstract])) AND ((((((((((inter disciplinar*[Title/Abstract]) OR Multidisciplinar*[Title/Abstract]) OR interdisciplinar*[Title/Abstract]) OR Multidisciplinary Care Team*[Title/Abstract]) OR "Community Health Nursing"[Mesh]) OR municipal*[Title/Abstract]) OR**	227925

Search	Add to builder	Query	Items found
		"Community Medicine"[Mesh]) OR ((primary[Title/Abstract] OR communit*[Title/Abstract]))) OR "Community Health Services"[Mesh]) OR "Primary Health Care"[Mesh])	
#34	Add	Search **(((((((("Health Education"[Mesh]) OR "Health Promotion"[Mesh])) OR "Harm Reduction"[Mesh]) OR "Preventive Health Services"[Mesh]) OR "Early Intervention (Education)"[Mesh]) OR harm reduct*[Title/Abstract]) OR ((health[Title/Abstract]) AND (promot*[Title/Abstract] OR educat*[Title/Abstract]))) OR ((early[Title/Abstract]) AND (intervent*[Title/Abstract] OR detection*[Title/Abstract]))) OR outreach[Title/Abstract]**	936035
#33	Add	Search **outreach[Title/Abstract]**	11204
#32	Add	Search **(early[Title/Abstract]) AND (intervent*[Title/Abstract] OR detection*[Title/Abstract])**	191232
#31	Add	Search **(health[Title/Abstract]) AND (promot*[Title/Abstract] OR educat*[Title/Abstract])**	278417
#29	Add	Search **harm reduct*[Title/Abstract]**	3614
#28	Add	Search **"Early Intervention (Education)"[Mesh]**	2499

Search	Add to builder	Query	Items found
#26	Add	Search **"Preventive Health Services"[Mesh]**	538009
#24	Add	Search **"Harm Reduction"[Mesh]**	2347
#22	Add	Search **("Health Education"[Mesh]) OR "Health Promotion"[Mesh]**	222694
#19	Add	Search **(((((((((inter disciplinar*[Title/Abstract]) OR Multidisciplinar*[Title/Abstract]) OR interdisciplinar*[Title/Abstract]) OR Multidisciplinary Care Team*[Title/Abstract]) OR "Community Health Nursing"[Mesh]) OR municipal*[Title/Abstract]) OR "Community Medicine"[Mesh]) OR ((primary[Title/Abstract] OR communit*[Title/Abstract]))) OR "Community Health Services"[Mesh]) OR "Primary Health Care"[Mesh]**	2095803
#18	Add	Search **inter disciplinar*[Title/Abstract]**	581
#17	Add	Search **Multidisciplinar*[Title/Abstract]**	67110
#16	Add	Search **interdisciplinar*[Title/Abstract]**	30278
#15	Add	Search **Multidisciplinary Care Team*[Title/Abstract]**	204
#12	Add	Search **"Community Health Nursing"[Mesh]**	19386

Search	Add to builder	Query	Items found
#10	Add	Search **municipal*[Title/Abstract]**	32910
#9	Add	Search **"Community Medicine"[Mesh]**	1960
#6	Add	Search **(primary[Title/Abstract] OR communit*[Title/Abstract])**	1721009
#5	Add	Search **"Community Health Services"[Mesh]**	277392
#2	Add	Search **"Primary Health Care"[Mesh]**	135420

B: Bench area A & B



C: Key Topic Interview Guide-The Men

Temaer	**Start spørgsmål**
Indledende spørgsmål	Tak fordi du vil deltage. Jeg stiller nu nogle indledende spørgsmål, der vil give mig et indblik i, hvem du er og hvordan dit liv ser ud. • Kan du fortælle lidt om dig selv?
Sundhed	Nu vil jeg gerne tale lidt om sundhed. Det vil sige, hvad du tænker om sundhed og hvad det betyder for dig? • Er sundhed noget du tænker over? • Hvilken betydning har det for dig at leve et sundt liv? • Hvilken type problemer har du mest brug for hjælp til if. sundhed? • Hvem taler du med, når du har det skidt? • Hvad gør du (eksempler) • Har du fysiske/psykiske helbredsproblemer, der ofte påvirker dit liv?
Sundhedsadfærd	Nu vil jeg gerne, hvis vi kan tale om, hvordan du lever til dagligt • Kan du fortælle hvordan din hverdag ser ud?
Sundhedskompetencer	Jeg vil nu spørge dig ind til, hvordan du får og anvender viden om sundhed • Ved du hvor du kan henvende dig, hvis du ikke har det godt? • Ved du hvor du skal henvende dig, hvis du vil slutte med at ryge? • Hvordan oplever du den besked du får fra sundhedsprofessionelle? • Hvad tænker du om de forskellige informationer du får om sundhed?

	○ Kender du til anbefalinger if. rygning, alkohol, kost, aktivitet ○ Er det let at forstå? ○ Bruger du det til noget? • Hvad er med til at inspirere dig til at vide mere om sundhed
Kontakter til sundheds- og socialsektoren – og opsøgende arbejde	Nu vil jeg gerne spørge dig ind til din kontakt til sundhedssektoren. Først til dit kendskab med opsøgende sundhedsarbejde. • Har du været i kontakt med opsøgende medarbejdere? ○ Hvordan har din oplevelse været? – uddyb. • Hvor ofte går du til læge? ○ Er det den samme læge hver gang du kommer? • Bruger du andre former for behandling? Hvilke? Hvorfor? Hvor? • Har du kendskab til kommunale sundhedstilbud?
Sociale netværk	• Hvilke sociale netværk indgår du i? • Hvor mødes i? • Hvilken betydning har det at mødes med vennerne? • Taler i nogen sinde om sundhed? - uddyb • Hjælper i nogensinde hinanden med sundhed? – uddyb • Hvad hjælper i hinanden med?

D: Key Topic Interview Guide-The Municipal Employee

Organisatoriske forhold	Afklaring af organisatoriske tilhørsforhold?
Tilbud til målgruppen af 'ikke-synlige' midaldrende mænd	• Hvilke tilgængelige og relevante sundhedstilbud findes der i til 'ikke-synlige' midaldrende mænd? • Oplever du, at sundhed er vigtig blandt 'ikke-synlige' borgergrupper eller er der andre ting, der fylder mere? • Hvordan vurderer du behovet for sundhedsindsatser til 'ikke-synlige' borgergrupper? • Hvilke erfaringer har du med gruppen af 'ikke-synlige' midaldrende mænd?
Sundheds- og socialindsatser	• Kan du fortælle om hvilke sundheds- og sociale indsatser du er involveret i? • Er indsatsen udbudt som selvfremmøde eller er der mulighed for opsøgende indsats? o Hvilke indsatser if. Sundhedsloven tilbydes? o Hvilke indsatser if. Serviceloven tilbydes? • Hvordan finansieres nye indsatser typisk? • Hvordan er arbejdsgangen if. et sundhedstilbud eller en social indsats o Hvem beslutter tilbuddet/indsatsen? o Evaluering af tilbuddet? Indsatsen? o Beslutning om videreførelse o Hvordan er borgerne inddraget i planlægningen og udførelsen af sundhedstilbud? o
Rammer for tilbud	• Hvem varetager konkrete sundhedsindsatser? Pædagoger, socialrådgivere, sygeplejersker, sundhedsambassadører? o Hvilket grundlag har medarbejderne til at udføre sundhedsfaglige opgaver? o Findes der instrukser eller tilsvarende if. hvad medarbejderne kan gøre ved

	sundheds- og sociale problemstillinger? • Dokumentationspraksis o Hvilken dokumentationspraksis er der ex. indenfor socialforvaltningens område if. sundhedsproblematikker? o Og omvendt? • Er der retningslinjer for videndeling i if. indsatser til bestemte målgrupper, som kan befinde sig under forskellige forvaltninger? o Anvendes ex. Gadesygeplejersken og Bo-og-gadeteamets erfaringer/viden? o Andres viden?
Proaktive indsatser	• Fortæl om det proaktive arbejde du kender til i Aalborg Kommune – ex- i de bolig sociale områder? • Erfaringer med opsøgende arbejde? • Er der retningslinjer if. fremskudt åben rådgivning/vejledning? • Er der retningslinjer/politikker if. proaktive indsatser?

E: Mail: Ethical Approval Scientific Ethical Committee

Kære Annette Pedersen

Du har ved mail af 12. april 2016 forespurgt Den Videnskabsetiske Komité for Region Nordjylland om anmeldelsespligt at dit planlagte projekt.

Det oplyses, at der er tale om et etnografisk studie, hvor formålet er at beskrive samt undersøge, hvad der karakteriserer 45-65 årige mænds oplevelse af sundhed, deres sundhedsadfærd mv. Desuden ønskes tilgængelige og relevante sundhedstilbud til deres rådighed også undersøgt. Målet er på den baggrund at komme med anbefalinger til sundhedsfremmende tiltag samt tidlig opsporing af sygdom, der imødekommer sårbare midaldrende mænds situtation og levebetingelser. Undersøgelserne foregår ved feltstudier, interviews og dokumentanalyse.

På baggrund af de fremsendte oplysninger er det sekretariatets opfattelse, at projektet *ikke* er omfattet af komitélovens (lov nr. 593 af 14/6/2011) definition på et sundhedsvidenskabeligt forskningsprojekt og derfor ikke skal anmeldes til og godkendes af komitéen, jf. komitélovens § 14, stk. 1, jf. § 2, nr. 1-3.

Projektet kan iværksættes uden yderligere tilbagemelding fra Den Videnskabsetiske Komité for Region Nordjylland.

Klagevejledning: afgørelsen kan, jf. komitélovens § 26, stk. 1, indbringes for Den Nationale Videnskabsetiske Komité senest 30 dage efter, afgørelsen er modtaget. Den Nationale Videnskabsetiske Komité kan, af hensyn til sikring af forsøgspersoners rettigheder, behandle elementer af projektet, som ikke er omfattet af selve klagen. Klagen samt alle sagens dokumenter sendes til: Den Nationale Videnskabsetiske Komité – DKetik@DKetik.dk

Med venlig hilsen

SEKRETARIATET for DEN VIDENSKABSETISKE KOMITÉ for REGION NORDJYLLAND
Niels Bohrs Vej 30
9220 Aalborg Ø
Tlf. 97 64 84 40
vek@rn.dk
www.vek.rn.dk

F: Mail: Ethical Approval Data Protection Agency

Kære Iben

Som du måske erindrer fra Uddannelseschef mødet den 01.12.2015, har Datatilsynet ændret procedure omkring anmeldelse og tilsyn med behandling af forskningsdata.

Ændringen medfører, at anmeldelser om dataindsamling til statistiske og forskningsmæssige projekter nu skal anmeldes til UCN og at UCN herefter har tilsynspligten ift. korrekt håndtering af dette data.

Du erindrer måske også, at denne tilsynspligt er blevet uddelegeret til Uddannelsescheferne. Jeg skriver derfor for at orientere dig om, at der i perioden april 2015-november 2019 vil blive indsamlet og behandlet forskningsdata ifm. Annette Pedersens ph.d-projekt.

Dataansvarlig og Databehandler er Annette Pedersen – som er cc. på denne mail. Annette har udfyldt en anmeldelse af dataindsamlingen, som du vil kunne finde her FOU-PHD-003.docx

Det er således nu din opgave at føre tilsyn med at databehandlingen sker i henhold til gældende lovgivning – tilsynet skal som minimum foretages halvårligt. Jeg har i dag tilset at Annette har oprettet en låst mappe med afgrænset brugeradgang på UCNemDok, hvori hun skal opbevare det elektroniske datamateriale. Derudover er vi, som bekendt i gang med at udrulle et workflow og en række yderligere tiltag ift. håndteringen af dette data.

Så der vil komme yderligere information ud til dig, så snart vi har noget nyt. Men skulle der indtil da være spørgsmål, er du naturligvis mere end velkommen til at kontakte mig.

De bedste hilsner fra

Henriette Frahm, Konsulent
Forskning og Udvikling
University College Nordjylland
Selma Lagerløfs Vej 2
9220 Aalborg Øst
Telefon nr.: 7269 0345
E-mail: hef@ucn.dk

Web: www.ucn.dk

G: Information Material-The Men

Kære interesserede,
Først vil jeg gerne sige tak for din interesse i forskningsprojektet 'Sundhedsfremme og tidlig opsporing af sygdom hos mænd mellem 45-65 år'.

Mit navn er Annette Pedersen. På baggrund af mit mangeårige arbejde som sygeplejerske, er jeg særligt interesseret i forebyggende sundhedsarbejde i kommunen samt lighed i sundhed for alle borgere. I januar 2016 startede jeg arbejdet med dette forskningsprojekt, fordi vi mangler viden om, hvordan kommunen bedst kan forbedre indsatsen omkring sundhed og sygdom for mænd mellem 45-65 år i Aalborg Kommune.

Jeg henvender mig til dig, fordi du er en mand mellem 45-65 år, der bor i Aalborg Kommune og som jeg gerne vil etablere et samarbejde med.

Forskningsprojektet har fokus på at undersøge, hvordan du opfatter sundhed og sygdom samt hvilke ønsker og behov du har i forhold til sundhed og sygdom. **I**nterviewene vil tage ca. 15-45 minutter, og der er ingen rigtige eller forkerte svar. Samtalerne bliver optaget på bånd og vil blive slettet, når undersøgelsen afsluttes. Din besvarelse er anonym, og jeg behandler alle samtaler fortroligt.
Desuden kunne jeg tænke mig, at deltage i nogle af dine daglige gøremål og aktiviteter i og/eller udenfor hjemmet, alt efter hvad du har mulighed for og ønske om. Det kan være besøg hos lægen, sygeplejersken eller andre former for sundhedstilbud i kommunen, hjemmeliv, indkøb, blot for at nævne nogle muligheder.

Jeg håber, at du er interesseret i at dele netop din viden, erfaring og oplevelser med mig og på den måde bidrage til en ny viden, der kan forbedre og udvikle indsatsen indenfor sundhedsområdet for mænd.

Du kan ringe til mig, hvis du vil deltage i projektet eller du kan lade den person, der har udleveret dette informationsbrev til dig videreformidle dine kontaktoplysninger til mig, og så vil jeg kontakte dig snarest herefter.

Har du spørgsmål er du velkommen til at kontakte mig på mobil: 72 69 12 10.

Med venlig hilsen
Annette Pedersen
Sygeplejerske og Ph.d. studerende,
University College Nordjylland, Selma Lagerløfsvej 2, 9220 Aalborg Ø

H: Information Material-The Municipal Employees

Information vedr. forskningsprojekt om sårbare mænd i Aalborg Kommune

En gruppe af mænd mellem 45-65 år i Aalborg Kommune er blevet identificeret som sårbare og med risikabel sundhedsadfærd. Mændene er karakteriseret ved at være svære at nå og 'ikke-synlige' med manglende og/eller sparsom kontakt til sundheds- og/eller socialsystemet. De anvender tilsyneladende ikke tilgængelige kommunale sundheds- og socialtilbud, hvilket kan være med til at øge ulighed i sundhed for denne gruppe borgere.

Jeg kontakter dig fordi jeg er i gang med at afdække, hvilke tilgængelige og relevante kommunale sundheds- og social tilbud, der er til 'ikke-synlige' midaldrende mænd i Aalborg Kommune. Dette sker i forbindelse med mit ph.d. projekt, der har titlen: Tidlig opsporing af sundhedsudfordringer hos 'ikke-synlige' midaldrende mænd mellem 45-65 år i Aalborg kommune.

Dette vil jeg undersøge bl.a. ved at interviewe forskellige medarbejdere i Aalborg Kommune samt evt. opleve og observere forskellige social- og sundhedstilbud i kommunen, der er tilgængelige og relevante for 'ikke-synlige' midaldrende mænd i Aalborg Kommune.

Jeg kontakter dig på foranledning af nøgle-kontaktpersoner i Familie- og Beskæftigelsesforvaltningen og Sundheds- og Kulturforvaltningen. Du er blevet anbefalet som mulig deltager i projektet grundet din viden om tilgængelige og relevante tilbud til 'ikke-synlige' midaldrende mænd eller fordi du arbejder med social- og/eller sundhedstilbud til andre målgrupper med sammenlignelige udfordringer. Jeg håber derfor, at du som medarbejder i Aalborg Kommune, i første omgang vil stille op til et interview?

Ph.d. forskningsprojekt udføres i et samarbejde mellem Center for voksne i Familie- og Beskæftigelsesforvaltningen; Sundhedscentercenter Aalborg, Center for Anvendt Kommunal Forskning (CAKSA) i Sundheds- og Kulturforvaltningen; Sygeplejerskeuddannelsen samt forskningsprogrammet Udsathed og Chanceulighed på University College Nordjylland (UCN); Forskningsenhed for Klinisk Sygepleje på Aalborg Universitetshospital; Klinisk Institut på Aalborg Universitet (AAU).

Har du behov for yderligere information om projektet, så kontakt mig endelig. På forhånd tak.

Med venlig hilsen

Annette Pedersen, Ph.d. studerende, Lektor, Sygeplejerske
Mobil: 72 69 10 52, Mail: aep@ucn.dk

I: Consent Formula–The men

Tilladelse til at bruge mine oplysninger i forskningsprojektet

Jeg giver hermed mit samtykke til, at den information som videregives i interviews, samt observationer fra din dagligdag må anvendes i forskningsprojektet 'Sundhedsfremme og tidlig opsporing af sygdom hos mænd mellem 45-65 år.

Jeg bekræfter at:

- Jeg har modtaget skriftlig og mundtligt information om projektet
- Jeg er informeret om, at det er frivilligt at deltage i interviews og at jeg til enhver tid kan trække mit samtykke tilbage uden begrundelse herfor
- Jeg er informeret om, at det er frivilligt om jeg vil deltage i, at Annette Pedersen følger mig i min dagligdag, og at jeg til enhver tid kan trække mit samtykke tilbage uden begrundelse herfor
- Jeg er bekendt med, at interviews og samtaler vil blive optaget på bånd, men vil blive slettet, når undersøgelsen afsluttes. Dette gælder også observationsnoter og andre registreringer i forbindelse med projektet
- Jeg er blevet informeret om, at deltagelse er helt anonymt, og at mine udsagn og andre registreringer vil blive anonymiseret. Mit navn og identifikationsoplysninger videregives ikke, men kendes kun af forskeren

Har du efterfølgende spørgsmål til deltagelse i projektet kan forsker Annette Pedersen kontaktes
på mobil: 72 69 12 10

Dato: Underskrift:

For yderligere information
Annette Pedersen
Sygeplejerske & Ph.d.-studerende
University College Nordjylland, Selma Lagerløfsvej 2, 9220 Aalborg Ø
Mobil: 72 69 12 10

J: Consent Formula–The Municipal Employees

Samtykke til at deltage i forskningsprojekt

Hermed giver jeg samtykke til, at den information, der videregives i interviews samt ved observationer må anvendes i forskningsprojektet: Tidlig opsporing af sundhedsudfordringer hos 'ikke-synlige' midaldrende mænd mellem 45-65 år i Aalborg Kommune.

Jeg bekræfter at:

- Jeg har modtaget skriftlig og mundtlig information om projektet
- Jeg er informeret om, at det er frivilligt at deltage og at jeg til en hver tid kan trække mit samtykke uden begrundelse herfor
- Jeg er informeret om, at interviews og samtaler vil blive optaget på bånd, men vil blive slettet, når undersøgelsen afsluttes. Dette gælder også observationsnoter og andre registreringer i forbindelse med projektet
- Jeg er blevet informeret om, at deltagelse er helt anonymt, og at mine udsagn og andre registreringer vil blive anonymiseret. Mit navn og identifikationsoplysninger videregives ikke, men kendes kun af forskeren

Dato: Underskrift:

For yderligere information

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